fiscal 2011-2012 **Q4**

4th quarter ended March 31, 2012

KGH this quarter

Master Performance Report

Kingston General Hospital

Outstanding care, always

KINGSTON GENERAL HOSPITAL

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Strategy milestone # 1

15 patient experience advisors are integrated into KGH committees

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Transform the patient experience through a relentless focus on quality, safety and service	**Patients are engaged in all aspects of our quality, safety and service improvement initiatives**	**Integrate patient experience advisors into key KGH activities**

Indicator(s)	Status
Number of Patient Experience Advisors on Key Planning/Decision Making Forums	**Green**

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   As previously report, the 2012 target was met in Q1. At the end of Q4, KGH has 43 Patient Experience Advisors engaged on committees or with activities directly linked to planning or decision making related to patient care improvements. There are 60 advisor positions on 28 long terms/standing committees and 48 on short term groups Advisors have been active participants in 26 presentations, and supported the hiring process in more than 30 interviews. The hours in the past year supported by advisors in direct activities are equivalent to 1.5 Full time positions.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   There is increasing awareness both internally and externally to the presence and work of the Patient and Family Advisory Council and the advisors. This awareness generates interest and enthusiasm. Ongoing education and exposure to other leading practices through connection to the Patients Association of Canada, the Institute for Patient and Family Centred Care (US based), the Change Foundation, close association to colleagues at Georgia Health Sciences (formerly Medical College of Georgia – MCG) and networking with other centres continues to fuel ideas and opportunities.

3. **Are we on track to meet the milestone by year end?**
   The target has been met and exceeded.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   The focus for the next year will be on implementing patient led feedback forums in each clinical program that trigger improvement processes. There will also be design of education programs for advisors and staff to enable sustainability of existing processes, and expansion of ways for patients and families to be partner in improving the patient experience.

Kingston General Hospital

Milestone #1

				10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
SD1 Transform the patient experience	15 Patient experience advisors are integrated into KGH committees		Number of Patient Experience Advisors on Key Planning/Decision Making Forums	Y	G	G	G	G	↑

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

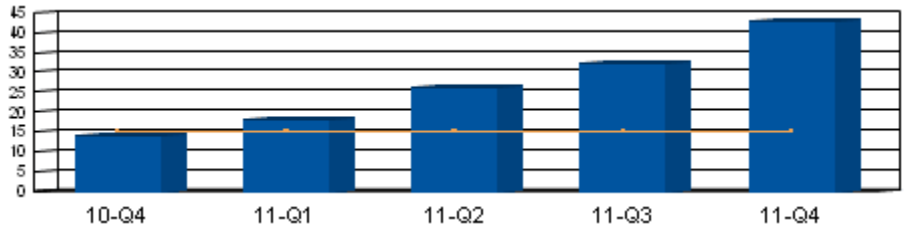
Kingston General Hospital

Milestone #1

SD1 Transform the patient experience through a relentless focus on quality, safety and service

15 Patient experience advisors are integrated into KGH committees

Indicator: Number of Patient Experience Advisors on Key Planning/Decision Making Forums



	Actual	Target
10-Q4	14	**15**
11-Q1	18	**15**
11-Q2	26	**15**
11-Q3	32	**15**
11-Q4	43	**15**

Interpretation - Patient And Business:

43 Patient Experience Advisors now hold positions on councils, committees and working groups throughout the organization. This ensures that the patient voice is being heard where many decisions on patient care are being made.

Actions & Monitoring Underway to Improve Performance:

All Program Councils now have at least one patient experience advisor (Cardiac Program Council has 3 advisors).

The Regional Cancer Patient and Family Advisory Council have recruited 11 patient experience advisors to date. The goal is to have 15 advisors on the regional council. We will continue to interview applicants for the position of patient experience advisor and build up a resource pool from which we can fill vacancies as needed.

Definition: KGH is committed to ensuring the patient voice is heard at every level of the organization. To that end Patient Experience Advisors are being recruited and supported for membership on all councils, committees, task forces and working groups which have anything to do with the patient experience.

Target: QIP 11/12 Target: 15

Strategy milestone # 2

Overall patient satisfaction is at or better than the provincial teaching hospital average

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Transform the patient experience through a relentless focus on quality, safety and service	Patients are engaged in all aspects of our quality, safety and service improvement initiatives	Improve patient satisfaction

Indicator(s)	Status
Overall Acute Inpatient Satisfaction	Green
Overall Emergency Care Patient Satisfaction	Green

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   The most recent data, for Q1 2012, demonstrates that KGH has met the target of being at or better than the provincial teaching hospital average with the KGH result being 94.2% satisfaction, the Ontario Teaching Hospital average being 94.1% and the Ontario average being 93.0%. The KGH standing is an improvement over the previous quarter from 93.9% On 7 of the 8 dimensions of inpatient care, KGH demonstrates improvement from the past quarter with the exception of “coordination of care” which fell from 74.1% to 73.5 percent.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   While patient satisfaction is multi-factorial, the focus and public transparency about improvements that influence the patient experience, including but not limited to patient flow and discharge planning, collaborative practice and communication, patient safety, environmental cleaning, likely contribute to improved performance. Staff support for improving the patient experience is and will remain a critical success factor.

3. **Are we on track to meet the milestone by year end?**
   Yes. Target has been met.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   In the next year, there will be review of the infrastructure and supports for the patient relations program with the goal of improving supports to the programs and the processes of followup and improvement. The work to sustain and improve the Interprofessional Collaborative Practice Model will support all dimensions of care. The full impact of engagement of patient experience advisors and corporate changes such as food service redesign have yet to be fully measured or realized.

Kingston General Hospital

Milestone #2

				10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	Overall patient satisfaction is at or better than the provincial teaching hospital average		Overall Acute Care Patient Satisfaction (%)	G	G	G	G	N/A	↑
			Overall Emergency Care Patient Satisfaction (%)	G	G	G	G	N/A	↑
			Percent of Patients Responding "Satisfied" to the Food Patient Discharge Survey	R	R	R	R	N/A	↓
			Percent of Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey	G	G	G	G	N/A	↓
			Percent of Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey (QIP)	Y	G	G	G	N/A	↓
			Percent of Patients who Answer "Definitely Yes" to the NRC Picker Question " Would you recommend this Hospital to Your Friends and Family	R	Y	G	G	N/A	↑
			Percent of Patients who Answer "Definitely Yes" to the NRC Picker question "Would you Recommend this Hospital to your Friends and Family (QIP)	Y	G	G	G	N/A	↑

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

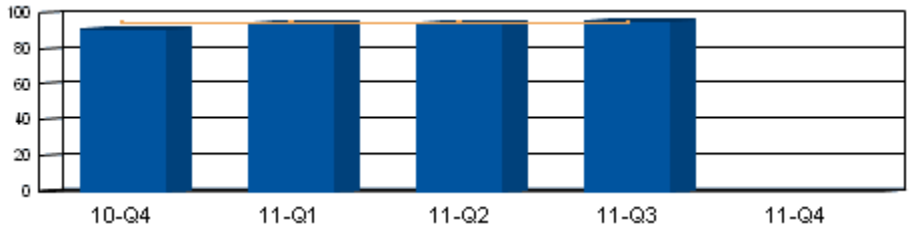
Kingston General Hospital

Milestone #2

SD1 Transform the patient experience through a relentless focus on quality, safety and service

Overall patient satisfaction is at or better than the provincial teaching hospital average

Indicator: Overall Acute Care Patient Satisfaction (%)

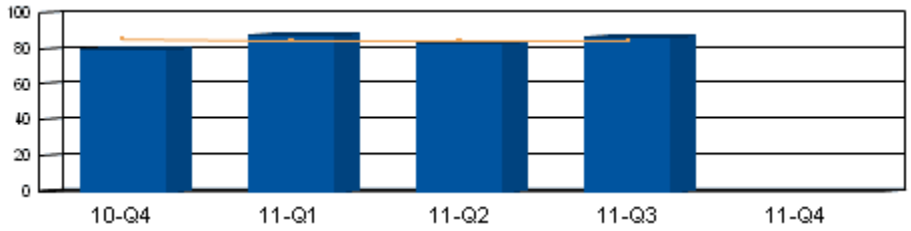


	Actual	Target
10-Q4	91	94
11-Q1	94	94
11-Q2	94	94
11-Q3	95	94
11-Q4		

Definition: The definition is the patient perception of overall care and is based on a single question (#44) on the NRC+ Picker inpatient medical/surgical survey. Pediatric, maternity and ambulatory care visits are excluded from participation. Ambulatory Care is reported elsewhere and is divided between 2 reports, Oncology reported annually and Emergency Care reported quarterly.

Target: Baseline 08/09: 93.3, Target 09/10: 93.8 or Greater, Target 10/11: Provincial Teaching Avg. or Better, Target 11/12: Provincial Teaching Avg. or Better

Indicator: Overall Emergency Care Patient Satisfaction (%)



	Actual	Target
10-Q4	80	85
11-Q1	87	84
11-Q2	83	84
11-Q3	86	84
11-Q4		

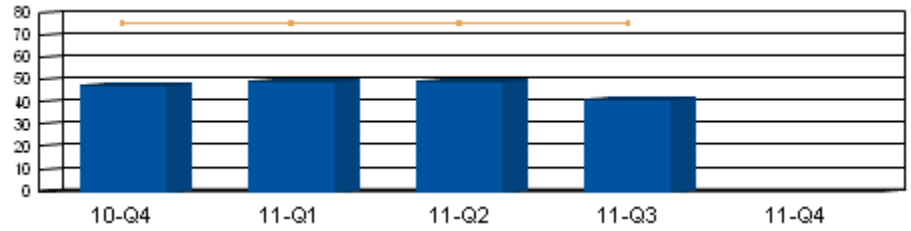
Interpretation - Patient And Business:

Actions & Monitoring Underway to Improve Performance:

Definition: This is defined as the patient perception of overall care and is based on the single question (# 46) on the NRC+ Picker survey. The question – Overall, how would you rate the care you received in the Emergency Department? The range is based on a 5 point scale of poor to excellent.

Target: Baseline 08/09: 83.1, Target 09/10: 80.0 or Greater, Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: Provincial Teaching Avg. Or Better.

Indicator: Percent of Patients Responding "Satisfied" to the Food Patient Discharge Survey



	Actual	Target
10-Q4	47	75
11-Q1	49	75
11-Q2	49	75
11-Q3	41	75
11-Q4		

Definition: This is one question on the NRC+ Picker patient satisfaction report and can be compared to the Ontario hospital average and the Ontario Teaching Hospital average.

Target: QIP Target 11/12: 75%

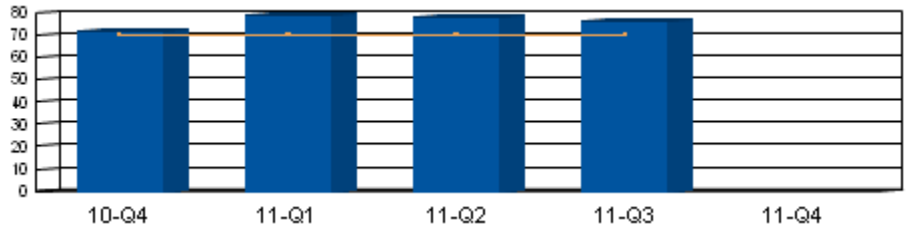
Kingston General Hospital

Milestone #2

SD1 Transform the patient experience through a relentless focus on quality, safety and service

Overall patient satisfaction is at or better than the provincial teaching hospital average

Indicator: Percent of Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey

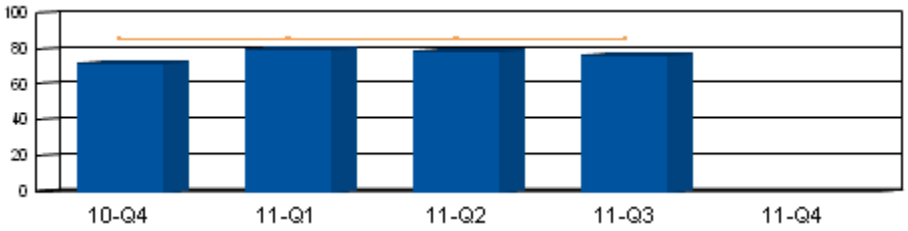


	Actual	Target
10-Q4	72	70
11-Q1	79	70
11-Q2	78	70
11-Q3	76	70
11-Q4		

Definition: The NRC + Picker corporate survey following discharge for condition of the room which include cleanliness, temperature and lighting.

Target: SSC 11/12 Target = 70%

Indicator: Percent of Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey (QIP)

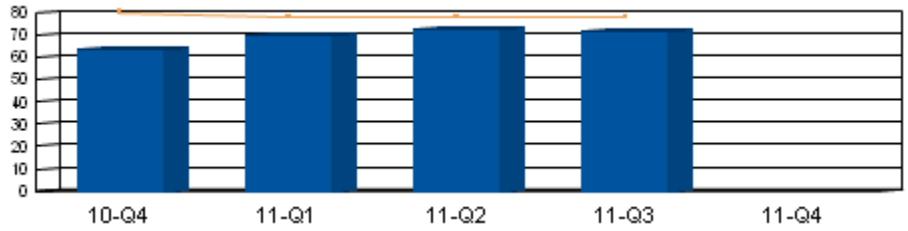


	Actual	Target
10-Q4	72	85
11-Q1	79	85
11-Q2	78	85
11-Q3	76	85
11-Q4		

Definition: The NRC + Picker corporate survey following discharge for condition of the room which include cleanliness, temperature and lighting.

Target: QIP Target 11/12: 85%

Indicator: Percent of Patients who Answer "Definitely Yes" to the NRC Picker Question " Would you recommend this Hospital to Your Friends and Family?"



	Actual	Target
10-Q4	64	80
11-Q1	70	78
11-Q2	73	78
11-Q3	72	78
11-Q4		

Definition: This is a single question from the NRC+ Picker patient satisfaction and can be compared to the Ontario Hospital average and the Ontario teaching Hospital average.

Target: 11/12 Target: Prov. Teaching Avg. or Better

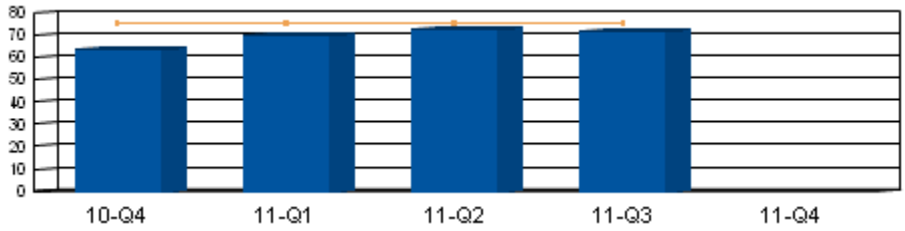
Kingston General Hospital

Milestone #2

SD1 Transform the patient experience through a relentless focus on quality, safety and service

Overall patient satisfaction is at or better than the provincial teaching hospital average

Indicator: Percent of Patients who Answer "Definitely Yes" to the NRC Picker question "Would you Recommend this Hospital to your Friends and Family"? (QIP)



	Actual	Target
10-Q4	64	**75**
11-Q1	70	**75**
11-Q2	73	**75**
11-Q3	72	**75**
11-Q4		

Definition: This is a single question from the NRC+ Picker patient satisfaction and can be compared to the Ontario Hospital average and the Ontario teaching Hospital average.

Target: QIP Target 11/12: 75%

Strategy milestone # 3

70% of our people who are surveyed rate us as "excellent" in fostering a patient safety culture

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Transform the patient experience through a relentless focus on quality, safety and service	All preventable harm to patients is eliminated	Improve our patient safety culture

Indicator(s)	Status
Percent of Staff Surveyed who Rate KGH "Very Good" or "Excellent" on the Patient Safety Culture Survey	Red

1. What is our actual performance on each of the indicators for this milestone as listed above?

The HSMR has risen for Q3 F11/12 to 128 and deemed to be a significant value. The annual HSMR has however been dropping steadily for the last 5 years. The mortality reviews have been completed by 100% of the clinical departments. There have been no concerning findings in the reviews to date. The recent Patient Safety Culture Survey was completed by 1201 respondents (39%), significantly improved from the Q1 survey (12% response rate). There was a 3% improvement in the staff who rated KGH very good or excellent. There were 5 less red indicators (30 vs 35) compared to the last survey.

2. What are the contributing factors to the current performance of the indicators for this milestone?

The continued vacancy of the Director of Patient Safety and Quality.

3. Are we on track to meet the milestone by year end?

The milestone is not on track and did not meet the targets for year end. HSMR data is reported from CIHI and 1-2 quarters behind. Annual trending would suggest it may hit target. The Patient Safety Culture Survey also did not meet the target of 70% but was improved from the last survey.

4. What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?

Recruitment for the Director position is in progress and will ensure the best candidate for the organization. Participation in ongoing patient safety campaigns such as 'Just Clean Your Hands", safety walks, and the Patient Safety and Quality Committee will continue to support the milestone through Accreditation promoting the patient safety agenda.

Kingston General Hospital

Milestone #3

				10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	70% of our people who are surveyed rate us as "Excellent" in fostering patient safety culture		Hospital Standardized Mortality Ratio (HSMR)	G	G	G	R	N/A	↓
			Percent Mortality Reviews Completed with Quarterly Review of Record Level HSMR Data	G	N/A	N/A	N/A	N/A	
			Percent of Staff surveyed who Rate KGH "Very Good" or "Excellent" on the Patient Safety Culture Survey	R	R	N/A	N/A	R	↑

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

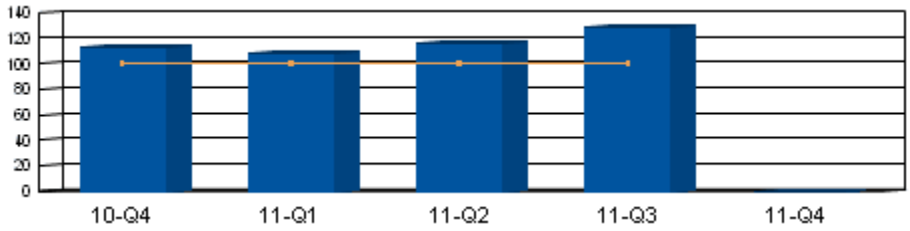
Kingston General Hospital

Milestone #3

SD1 Transform the patient experience through a relentless focus on quality, safety and service

70% of our people who are surveyed rate us as "Excellent" in fostering patient safety culture

Indicator: Hospital Standardized Mortality Ratio (HSMR)



	Actual	Target
10-Q4	113	**100**
11-Q1	108	**100**
11-Q2	116	**100**
11-Q3	128	**100**
11-Q4		

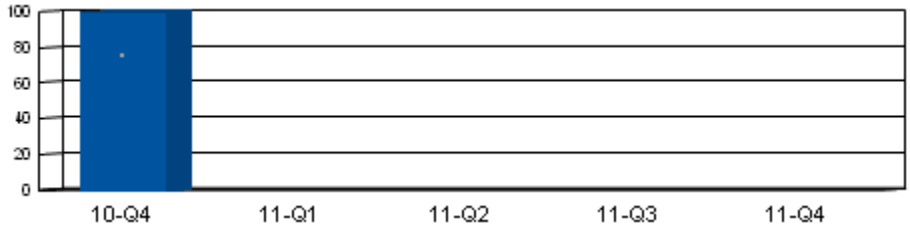
Actions & Monitoring Underway to Improve Performance:

The most recent data available data is Q3 fiscal 10/11. The HSMR has risen slightly and for Q3 fiscal 10/11 was deemed statistically significant. However, it is important to note that our HSMR has been dropping steadily for the past 5 years. The Canadian Institute for Health Information (CIHI) provides the HSMR calculations to all hospitals in Ontario. Quarterly morality reviews are ongoing by the clinical departments. Any concerns or trends are reported to the MAC's Joint Quality and Utilization Committee. Of note is a continued drop on the 5 year ANNUAL mortality rate.

Definition: The Hospital Standardized Mortality Ratio (HSMR) is an overall quality indicator and measurement tool used by all acute care hospitals and regions in Canada (excluding Quebec). HSMR has been used by many hospitals in several countries to help improve quality of care and enhance patient safety. The HSMR is based on diagnosis groups that account for 80% of all deaths in acute care hospitals and is adjusted for factors such as diagnosis group, age, sex, length of hospital stay, admission category, comorbidities (having multiple illnesses at once) and transfers. The Formula for HSMR is equal to the number of observed deaths divided by the number of expected deaths, multiplied by 100.

Target: Baseline 08/09: 111, Target 09/10: 100, Target 10/11: 100, Target 11/12: 106.

Indicator: Percent Mortality Reviews Completed with Quarterly Review of Record Level HSMR Data



	Actual	Target
10-Q4	100	**75**
11-Q1		
11-Q2		
11-Q3		
11-Q4		

Actions & Monitoring Underway to Improve Performance:

Our mortality review process focuses on the deaths that are identified through the HSMR calculation. Because we only just received the HSMR case level data for Fiscal 11/12 Q1 and Q2, the results are not yet available. They will be reported in Q1 of fiscal 12/13

Definition: Mortality reviews completed with quarterly review of record level HSMR data by Department Heads and reported to the Medical Advisory Committee

Target: QIP Target 11/12: 75%

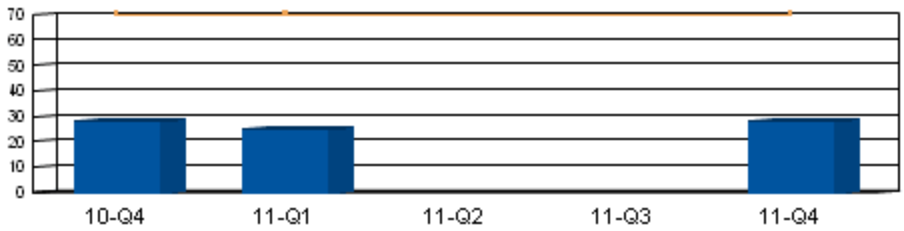
Kingston General Hospital

Milestone #3

SD1 Transform the patient experience through a relentless focus on quality, safety and service

70% of our people who are surveyed rate us as "Excellent" in fostering patient safety culture

Indicator: Percent of Staff surveyed who Rate KGH "Very Good" or "Excellent" on the Patient Safety Culture Survey



	Actual	Target
10-Q4	28	**70**
11-Q1	25	**70**
11-Q2	N/A	**70**
11-Q3	N/A	**70**
11-Q4	28	**70**

Interpretation - Patient And Business:

The follow-up Patient Safety Culture survey was completed by 1201 respondents (39%) significantly up from the last survey were only a 12% response rate was seen with 363 respondents. There was a 2% increase in the staff rating KGH as Excellent or Very Good on patient safety. The current survey showed 30 red and 10 yellow indicators shifted from 35 red and 5 yellow in May 2011. The improvement was seen in 5 different indicators turning yellow. The previous 5 yellow remained yellow. For the majority of the 40 questions there was a shift to an improved score

Actions & Monitoring Underway to Improve Performance:

There was a 3.3 fold increase in respondents completing the survey. A 3% improved response will continue to focus efforts and actions to support these improvements: using the SAFE reporting e-learning module introducing safety concepts, the recruitment of the new position Director Quality & Patient Safety and work of the Patient Quality and Safety Committee.

Definition: The Patient Safety Culture Tool provides insight into staff perceptions of patient safety, allowing us to identify successes and opportunities for improvement, and monitor changes within the organization. It is based on the Modified Stanford Instrument (MSI) Patient Safety Culture Survey developed by Ginsburg et. al. (York University) The tool was recently revised by Ginsburg et. al. to ensure it reflects the most up-to-date patient safety culture research.

The Patient Safety Culture Tool includes 40 items (plus demographic items). Two items assign an overall patient safety grade of the unit and the organization. The remaining 38 items measure the following dimensions:
- Senior leadership support for safety
- Supervisory leadership support for safety
- Patient safety learning culture
- Talking about errors / communication barriers

The question on the Patient Safety Culture Survey reads;

"Please give your unit an overall grade on patient safety"
Staff responses to select from include;
- Excellent
- Very Good
- Acceptable
- Poor
- Failing

Target: Target 11/12: 70%

Strategy milestone # 4

We achieve 100% hand hygiene compliance across all units and categories of staff

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Transform the patient experience through a relentless focus on quality, safety and service	**All preventable harm to patients is eliminated**	**Reduce hospital-acquired infections**

Indicator(s)	Status
Hand Hygiene Compliance	**Green**

1. **What is our actual performance on each of the indicators for this milestone as listed above?**

   Hand hygiene compliance is at 94% for the organization.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**

   A broad institutional awareness of hand hygiene rates and impact has been in place since Q3 Fiscal 2009. The Handy Audit tool introduction through the CAHO ARTIC project has made data collection and analysis robust. Public reporting, frequent data analysis by all wards and posting on hospital wards and public entrances has maintained visibility on the awareness to meet compliance targets.

3. **Are we on track to meet the milestone by year end?**

   The Q4 and year end target of 90% was exceeded by 4%.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**

   Continued executive messaging supporting 100% hand hygiene compliance. Compliance accountability is tied to Infection Control Service and Infection Control Committee. Monthly Handi Audit reports are standing agenda at Infection Control and Patient Safety and Quality Committee meetings.

Kingston General Hospital

Milestone #4

				10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	We achieve 100% hand hygiene compliance across all units and categories of staff		Hand Hygiene Compliance	G	Y	Y	G	G	↑
			Hand Hygiene Compliance (QIP)	N/A	Y	Y	G	G	↑
			Hand Hygiene Compliance (SSC)		Y	Y	Y	G	↑

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

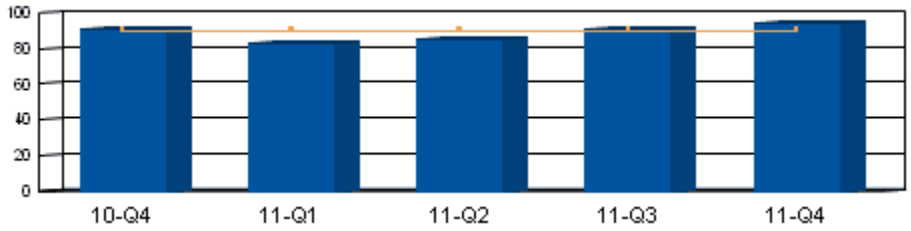
Kingston General Hospital

Milestone #4

SD1 Transform the patient experience through a relentless focus on quality, safety and service

We achieve 100% hand hygiene compliance across all units and categories of staff

Indicator: Hand Hygiene Compliance



	Actual	Target
10-Q4	91	**90**
11-Q1	83	**90**
11-Q2	85	**90**
11-Q3	91	**90**
11-Q4	94	**90**

Interpretation - Patient And Business:

Continued messaging about Hand Hygiene and the use of the Handyaudit tool has had the desired effect on reaching our target for hand hygiene compliance. Continued attention to HH across the institution will be important to reducing the incidence of nosocomal infections overall

Definition: The single most common way of transferring health care-associated infections (HAIs) in a health care setting is on the hands of health care providers. Health care providers move from patient to patient and room to room while providing care and working in the patient environment. This movement provides many opportunities for the transmission of organisms on hands that can cause infections. Hand hygiene is the act of cleaning one's hands. There are two ways to clean hands; using an alcohol-based hand rub (ABHR) or, when hands are visibly soiled, using soap and running water. Monitoring hand hygiene practices is vital to improving rates and, in turn, reducing HAIs.
Hospitals will post on their web sites, on an annual basis and by hospital site, the compliance rate for: hand hygiene before initial contact with the patient/patient's environment for all health care providers as well as hand hygiene after contact with the patient/patient's environment for all health care providers.

Before Initial Patient/Patient Environment Contact :
# of times hand hygiene performed before initial patient/patient environment contact
---
observed hand hygiene indications before initial patient/patient environment contact x 100

After Patient/Patient Environment Contact :
# of times hand hygiene performed after patient/patient environment contact
---
observed hand hygiene indications after patient/patient environment contact x 100
Hospitals will also report their data to the Ministry of Health and Long-Term Care through an online template captured by a central database. The ministry will post this information on its public website.

This indicator is based on the Average compliance for all four moments of Hand Hygiene (Before initial patient/patient environtment contact, Before aseptic procedures, After patient/patient environment contact, After body fluid exposure risk)
- for all professions

Target: Baseline Fiscal 08/09: 44%, Target 09/10: 90%, Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: 90%

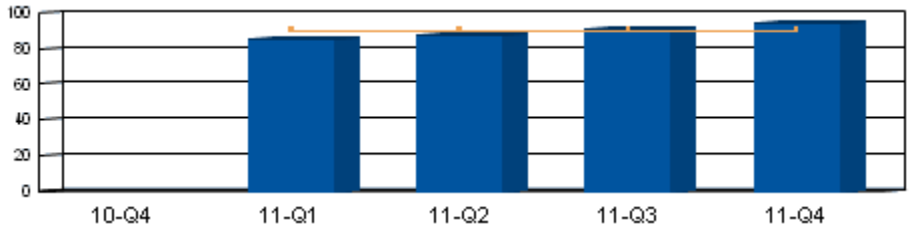
Kingston General Hospital

Milestone #4

SD1 Transform the patient experience through a relentless focus on quality, safety and service

We achieve 100% hand hygiene compliance across all units and categories of staff

Indicator: Hand Hygiene Compliance (QIP)



	Actual	Target
10-Q4		
11-Q1	85	**90**
11-Q2	87	**90**
11-Q3	91	**90**
11-Q4	94	**90**

Interpretation - Patient And Business:

Continued messaging about Hand Hygiene and the use of the Handyaudit tool has had the desired effect on reaching our target for hand hygiene compliance. Continued attention to HH across the institution will be important to reducing the incidence of nosocomal infections overall.

Definition: The single most common way of transferring health care-associated infections (HAIs) in a health care setting is on the hands of health care providers. Health care providers move from patient to patient and room to room while providing care and working in the patient environment. This movement provides many opportunities for the transmission of organisms on hands that can cause infections. Hand hygiene is the act of cleaning one's hands. There are two ways to clean hands; using an alcohol-based hand rub (ABHR) or, when hands are visibly soiled, using soap and running water. Monitoring hand hygiene practices is vital to improving rates and, in turn, reducing HAIs.
Hospitals will post on their web sites, on an annual basis and by hospital site, the compliance rate for: hand hygiene before initial contact with the patient/patient's environment for all health care providers as well as hand hygiene after contact with the patient/patient's environment for all health care providers.

Before Initial Patient/Patient Environment Contact :
# of times hand hygiene performed before initial patient/patient environment contact
---
observed hand hygiene indications before initial patient/patient environment contact x 100

After Patient/Patient Environment Contact :
# of times hand hygiene performed after patient/patient environment contact
---
observed hand hygiene indications after patient/patient environment contact x 100
Hospitals will also report their data to the Ministry of Health and Long-Term Care through an online template captured by a central database. The ministry will post this information on its public website.

This indicator is based on the compliance rate for hand hygiene before initial patient / Patient environment contact for all professions

Target: QIP Target 11/12: 90%

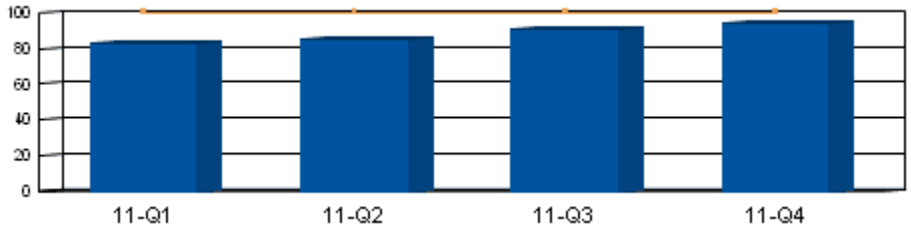
Kingston General Hospital

Milestone #4

SD1 Transform the patient experience through a relentless focus on quality, safety and service

We achieve 100% hand hygiene compliance across all units and categories of staff

Indicator: Hand Hygiene Compliance (SSC)



	Actual	Target
11-Q1	83	**100**
11-Q2	85	**100**
11-Q3	91	**100**
11-Q4	94	**100**

Interpretation - Patient And Business:

Continued messaging about Hand Hygiene and the use of the Handyaudit tool has had the desired effect on increasing compliance with hand hygiene that are now approaching our specified target of 100%. Continued attention to HH across the institution is important in reducing the overall incidence of nosocomal infections.

Definition:

The single most common way of transferring health care-associated infections (HAIs) in a health care setting is on the hands of health care providers. Health care providers move from patient to patient and room to room while providing care and working in the patient environment. This movement provides many opportunities for the transmission of organisms on hands that can cause infections. Hand hygiene is the act of cleaning one's hands. There are two ways to clean hands; using an alcohol-based hand rub (ABHR) or, when hands are visibly soiled, using soap and running water. Monitoring hand hygiene practices is vital to improving rates and, in turn, reducing HAIs.
Hospitals will post on their web sites, on an annual basis and by hospital site, the compliance rate for: hand hygiene before initial contact with the patient/patient's environment for all health care providers as well as hand hygiene after contact with the patient/patient's environment for all health care providers.

Before Initial Patient/Patient Environment Contact :
# of times hand hygiene performed before initial patient/patient environment contact
---
observed hand hygiene indications before initial patient/patient environment contact x 100

After Patient/Patient Environment Contact :
# of times hand hygiene performed after patient/patient environment contact
---
observed hand hygiene indications after patient/patient environment contact x 100
Hospitals will also report their data to the Ministry of Health and Long-Term Care through an online template captured by a central database. The ministry will post this information on its public website.

This indicator is based on the Average compliance for all four moments of Hand Hygiene (Before initial patient/patient environtment contact, Before aseptic procedures, After patient/patient environment contact, After body fluid exposure risk), for all professions.

Target: SSC Target 11/12: 100%

Strategy milestone # 5

The number of new patients who acquire infections in our hospital is reduced by 10%

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Transform the patient experience through a relentless focus on quality, safety and service	**All preventable harm to patients is eliminated**	**Reduce hospital-acquired infections**

Indicator(s)	Status
Number of New Cases of Hospital Acquired Infection	**Red**

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   There are 9 separate reported indicators in this milestone. Five are green (Central line infections, environmental audits, MRSA infections, Ventilator associated pneumonia, and VRE infections). There were 2 yellow (antibiotic dispensed, surgical site infection prevention). The 2 red indicators were C. difficile infection and the cumulative indicator the number of new cases of hospital acquired infections.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   CDI infection rates continues to be the predominate factor in this indicator. KGH has historically seen a seasonal spike in rates for Q3/Q4. In addition an outbreak in C difficile infection was declared during Q4.

3. **Are we on track to meet the milestone by year end?**
   This milestone did not reach target at year end. The ability to control C. diff. is the sole determinate for meeting the milestone.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**

   Prevention of hospital acquired infections is a complex and multi-faceted problem. There is a predominance of CDI case on carpeted units. KGH continues to remove carpets as quickly as possible (40% complete Q4). Hand hygiene compliance rates continue to climb and KGH rates are leading in our peer group. An antibiotic stewardship program is being implemented and aligned with the CAHO ARTIC project.

Kingston General Hospital

Milestone #5

			10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	The number of new cases who acquire infections in our hospital is reduced by 10%	Anti-biotics Dispensed Quarterly to ED and Admitted Patients per 1000 patient days	R	R	Y	R	Y	↑
		C-difficile	R	R	R	R	R	↓
		C-difficile (QIP)	R	G	R	R	R	↓
		Central Line Bloodstream Infections	G	G	R	G	G	↑
		Environmental Audits	G	Y	G	G	G	↑
		MRSA (Methicillin-resistant Staphylococcus aureus)	Y	Y	Y	G	G	↑
		Number of New Cases of Hospital Acquired Infection	R	G	Y	Y	R	↓
		Percent of Sepsis Cases Reviewed by Department Head	N/A	N/A	N/A	N/A	N/A	
		Surgical Site Infection (SSI) Prevention	Y	Y	Y	Y	Y	↑
		Ventilator Associated Pneumonia	G	G	G	G	G	↑
		Ventilator Associated Pneumonia (QIP)	G	G	G	G	G	↓
		VRE (Vancomycin-resistant Enterococcus)	G	Y	Y	G	G	↓

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

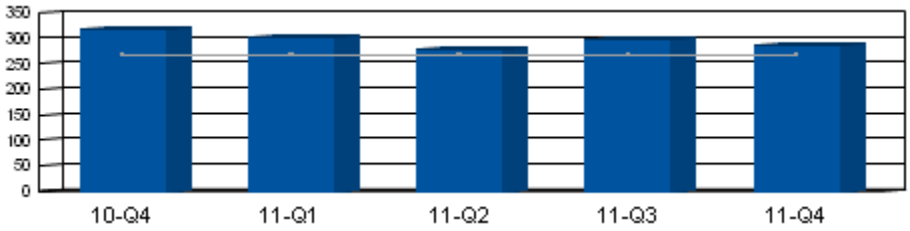
Kingston General Hospital

Milestone #5

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The number of new cases who acquire infections in our hospital is reduced by 10%

Indicator: Anti-biotics Dispensed Quarterly to ED and Admitted Patients per 1000 patient days



	Actual	Target
10-Q4	317	**267**
11-Q1	303	**267**
11-Q2	278	**267**
11-Q3	299	**267**
11-Q4	285	**267**

Interpretation - Patient And Business:

Antimicrobial resistance is a known major public health issue, and antimicrobial stewardship, the appropriate use of antimicrobial agents, is critical to stemming the continued emergence of antimicrobial-resistant organisms.

The increasing recognition of the health burden associated with hospital-acquired infections in Canada and the increasing evidence that the use of antimicrobials in hospitals is a critical determinant of infection rates due to the most important hospital-acquired pathogens, methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile, emphasize the urgency of developing and facilitating antimicrobial stewardship programs. Literature has shown that appropriate use of antimicrobials can reduce occurrences of antibiotic resistant organisms.

Actions & Monitoring Underway to Improve Performance:

As of Q4, KGH's usage of antibiotics remains above target but is improving and has do so over the entire fiscal 11/12 period. The Infection Prevention and Control Service continues to take the lead in implementation of an antibiotic stewardship program (ABSP) working with and through the Patient Safety and Quality Committee. Curtailing antibiotic usage is expected to have impact by reducing the incidence and frequency of nosocomial infections and outbreaks, especially C. difficile. The introduction of the Anti-biotic Stewardship program is aimed at monitoring and improving anti-biotic utilization. The project is being linked with the CAHO ARTIC project on antibiotic stewardship.

Definition: The Targeted Antimicrobial Use Indicator is a measure of institutional antimicrobial consumption of broad-spectrum antibacterials. Overuse of antibiotics is associated with the emergence of antimicrobial resistance and selection of some pathogens for example, Clostridium difficile. The indicator permits monitoring using a surrogate marker for institutional trends in overall antimicrobial use. Early warning of increasing patient exposure to antibiotics may become evident with monitoring. Conversely, the impact of interventions aimed at reducing overall patient exposure to antibiotics may become apparent. The total number of defined daily doses (DDD) of targeted antibiotics per 1000 patient-days using the World Health Organization Anatomical Class (WHO ATC) definition of DDD [assumed average maintenance dose per day for a drug used for its main indication in adults].The targeted antibiotics are: carbapenems (ertapenem, imipenem, meropenem, doripenem); third and fourth generation cephalosporins (cefepime, cefixime, cefotaxime, ceftazidime, ceftriaxone); extended-spectrum penicillins (piperacillin, piperacillin-tazobactam, ticarcillin-clavulanate); fluoroquinolones (ciprofloxacin, levofloxacin, moxifloxacin) and clindamycin. The numerator is the total DDDs of targeted antimicrobials, as extracted from GE Centricity Pharmacy Version 8.2 software reports detailing quarterly drug issuance to all patient care units, including Emergency. The denominator is the Quarterly Patient Days Grand Total from the Hospital's Bed Census Report.

Target: 267 DDD/1000 patient-days (based upon 5% reduction from that measured during Fiscal 2011 Q3.

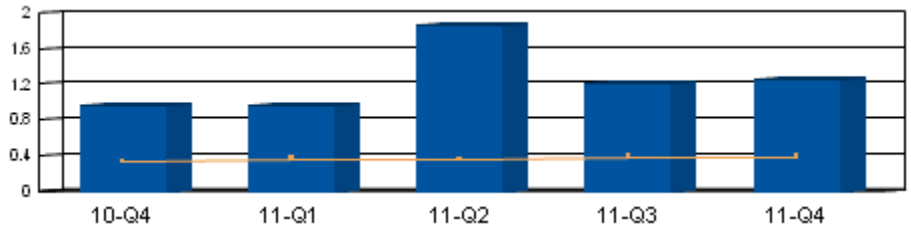
Kingston General Hospital

Milestone #5

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The number of new cases who acquire infections in our hospital is reduced by 10%

Indicator: C-difficile



	Actual	Target
10-Q4	0.96	**0.33**
11-Q1	0.95	**0.36**
11-Q2	1.86	**0.35**
11-Q3	1.21	**0.38**
11-Q4	1.26	**0.38**

Interpretation - Patient And Business:

The effect of seasonal variation resulted in a modest increase in CDI rates over the last quarter and an outbreak declaration in January 2012. Rates remain above targets but are stabilizing. In the approach to CDI, KGH recently approved an Antibiotic Stewardship Program, which will be an important component to controlling incident cases. Consistent improvements to environmental cleaning is also an important part of CDI control. Efforts to direct more hospital resources to the control of CDI should be considered. IPAC resources remain an issue and speak to the need to bring the team up to its requisite numbers of ICPs.

Business perspective: Investment in the Antibiotic Stewardship Program should help to reduce and maintain rates of CDI. Investments in improving Environmental Services to meet audit benchmarks would also bring a meaningful return in reducing CDI rates.

Note: Values in graph display the most recent 5-month period (November, 2011 - March, 2012).

Definition: Clostridium difficile is a spore-forming bacterium that may be present in the environment and can colonize the intestinal tract in up to five per cent of adults in the community without causing symptoms. It can cause an infectious diarrhea in both community and health care settings. It is the single most common cause of antibiotic-associated diarrhea (AAD) accounting for 15-25% of all episodes.

All Ontario hospitals are required to report to the MOHLTC and publicly on the rates and the number of new nosocomial CDI cases associated with the reporting facility.

The CDI count is the number of new nosocomial cases of CDI by month.
The rate of CDI is calculated as follows: The number of new nosocomial cases of CDI associated with the reporting facility multiplied by 1000, then divided by the number of patient days. This rate represents the incidence rate of nosocomial CDI associated with the reporting facility per 1000 patient days.

Target: Target 09/10: 0.26 Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: Provincial Avg. Or Better

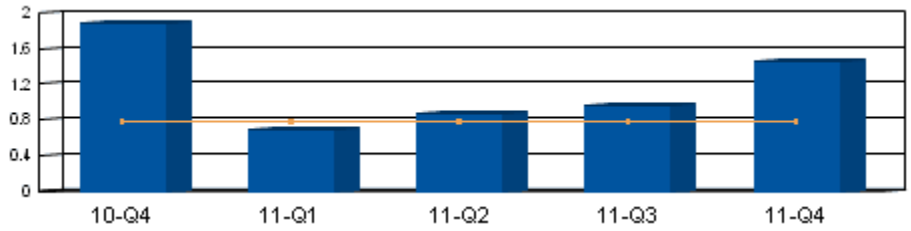
Kingston General Hospital

Milestone #5

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The number of new cases who acquire infections in our hospital is reduced by 10%

Indicator: C-difficile (QIP)



	Actual	Target
10-Q4	1.89	**0.77**
11-Q1	0.70	**0.77**
11-Q2	0.87	**0.77**
11-Q3	0.97	**0.77**
11-Q4	1.45	**0.77**

Interpretation - Patient And Business:

The effect of seasonal variation resulted in a modest increase in CDI rates over the last quarter and an outbreak declaration in January 2012. Rates remain above targets but are stabilizing. In the approach to CDI, KGH recently approved an Antibiotic Stewardship Program, which will be an important component to controlling incident cases. Consistent improvements to environmental cleaning is also an important part of CDI control. Efforts to direct more hospital resources to the control of CDI should be considered. IPAC resources remain an issue and speak to the need to bring the team up to its requisite numbers of ICPs.

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All Ontario hospitals are required to report to the MOHLTC and publicly on the rates and the number of new nosocomial CDI cases associated with the reporting facility.

The CDI count is the number of new nosocomial cases of CDI by month.
The rate of CDI is calculated as follows: The number of new nosocomial cases of CDI associated with the reporting facility multiplied by 1000, then divided by the number of patient days. This rate represents the incidence rate of nosocomial CDI associated with the reporting facility per 1000 patient days.

Target: QIP Goal = 0.30, QIP Target For Compensation = 0.77

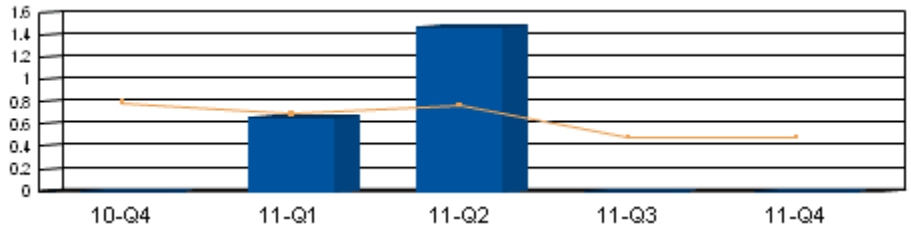
Kingston General Hospital

Milestone #5

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The number of new cases who acquire infections in our hospital is reduced by 10%

Indicator: Central Line Bloodstream Infections



	Actual	Target
10-Q4	0.00	**0.79**
11-Q1	0.66	**0.69**
11-Q2	1.47	**0.77**
11-Q3	0.00	**0.48**
11-Q4	0.00	**0.48**

Interpretation - Patient And Business:

Patient perspective: CLBI poses a significant risk of life threatening infection and increased critical are and hospital length of stay.
The last two quarters show no appreciable CLBI cases over a 6-month period. The use of a central line bundle and a patient safety coordinator who works with staff to ensure compliance in all aspects of the bundle have been very effective in changes in practice and maintaining our success in this measure.

Business perspective: small numbers have significant impact to the rates and hence q2 was high but overall ytd the rate achieved target as the last 2 quarters were 0.

Actions & Monitoring Underway to Improve Performance:

Continued monitoring of compliance with bundle and frequent updates of staff assists in heightening awareness of this indicator.

Definition: A central line infection (CLI) occurs when a central venous catheter (or "line") placed into a patient's vein becomes infected. A CLI occurs when excessive numbers of bacteria grow on the line, which can lead to blood stream infection. Patients may require a central line when blood, fluid replacement and/or nutrition need to be given to them intravenously. Central lines also allow health care providers to directly monitor fluid status and make determinations about the cardiovascular status of a patient.
A CLI case is defined as an ICU patient who developed a blood stream infection (BSI) a minimum of 48 hours after the insertion of a central line.

The ministry will report and post on its website by hospital site the number of CLI cases that developed in the ICU in each hospital site. Where the number is zero (0) or where the cases total five (5) or more associated with that hospital site, the number will be posted. If the cases are fewer than 5 (i.e., 1 to 4 cases), it will state "<5 cases" and the CLI rate (per 1000 central line days)

The CLI rate is determined by the total number of newly diagnosed CLI cases in the ICU after at least 48 hours of receiving a central line, divided by the number of central line days in that month, multiplied by 1,000. Central line days are the total number of days a central line was used in ICU patients 18 years and older.

Target: Target 09/10: 1.2 Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: Provincial Avg. Or Better

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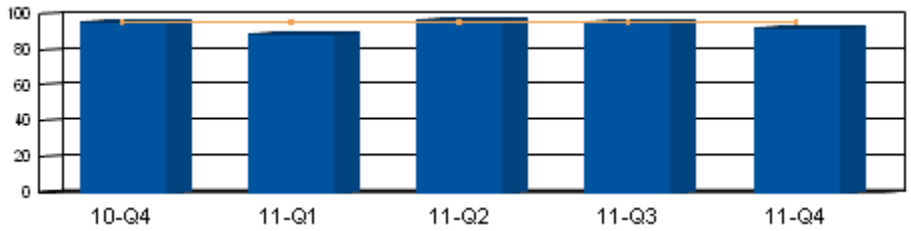
Indicator: Environmental Audits



	Actual	Target
10-Q4	95	**95**
11-Q1	88	**95**
11-Q2	96	**95**
11-Q3	95	**95**
11-Q4	92	**95**

Interpretation - Patient And Business:

Ongoing staff training continues to meet our stretch goal of 95% compliance

Actions & Monitoring Underway to Improve Performance:

Staff training on Best Practices cleaning is currently at 70%, with a goal of 100%. This training is important to ensure our 95% target.

Definition: The environmental audit indicator evaluates and measures the effectiveness of daily patient room cleaning. The audit identifies opportunities to focus education and training needs. The audit uses a glow germ potion and glow bar UV lamp on frequently touched surfaces in randomly selected patient rooms for an overall representation of cleaning. The percentage is determined on glow germ removed.

Target: QIP Target 11/12: 95%

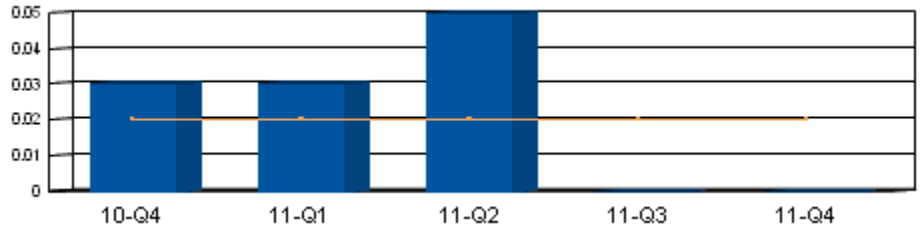
Kingston General Hospital

Milestone #5

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The number of new cases who acquire infections in our hospital is reduced by 10%

Indicator: MRSA (Methicillin-resistant Staphylococcus aureus)



	Actual	Target
10-Q4	0.03	0.02
11-Q1	0.03	0.02
11-Q2	0.05	0.02
11-Q3	0.00	0.02
11-Q4	0.00	0.02

Interpretation - Patient And Business:

There were no MRSA bacteremias again in the last quarter. This is attributable to excellent hand hygiene rates across the hospital. Colonization rates with MRSA amongst inpatients is also dropping, again likely a function of better HH rates. Judicious antibiotic use should also help to alleviate the pressure to select out antibiotic resistant organisms like MRSA. The introduction of an Antibiotic Stewardship Program at KGH should therefore help to maintain the low incidence of MRSA infections overall.

Definition: Staphylococcus aureus is a bacterium that periodically lives on the skin and mucous membranes of healthy people. Occasionally S. aureus can cause an infection. When S. aureus develops resistance to the beta lactam class of antibiotics, it is called methicillin-resistant Staphylococcus aureus, or MRSA.
A case is a patient identified with laboratory confirmed bloodstream infection with MRSA. A bloodstream infection is at least one positive blood culture for MRSA. KGH will post its quarterly rate and new case count of MRSA bacteraemia acquired in its facility on its website.
At the end of each quarter, the ministry will report the previous quarter's data on its website by hospital site including the number of new hospital acquired MRSA bacteraemia cases that is zero (0) or totaling five (5) or more associated with that hospital site, or if this is fewer than 5 cases (i.e. 1 to 4 cases), text reading "< 5 cases", and the hospital acquired MRSA bacteraemia rate.

The total number of new cases of MRSA bacteraemia acquired in the hospital in a quarter is divided by the total number of patient days for that quarter. Patient days are the number of days spent in a hospital for all patients. The results are multiplied by 1000. This represents the rate of hospital acquired associated MRSA bacteraemia associated with the reporting facility per 1000 patient days for that quarter.

Target: Target 09/10: 0.02 Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: Provincial Avg. Or Better

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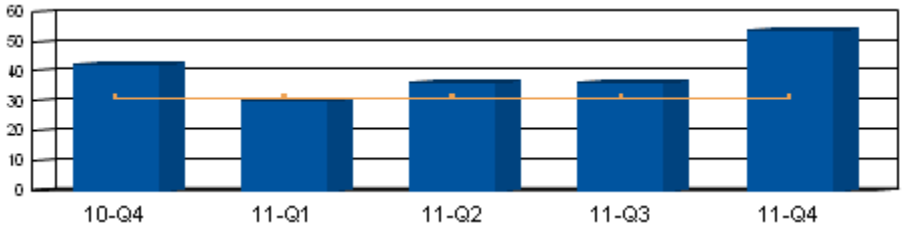
Indicator: Number of New Cases of Hospital Acquired Infection



	Actual	Target
10-Q4	42	31
11-Q1	30	31
11-Q2	36	31
11-Q3	36	31
11-Q4	54	31

Interpretation - Patient And Business:

The sudden increase in this indicator is in large part due to the major c.diff outbreak during Q4. Investment in the Antibiotic Stewardship Program should help to reduce and maintain rates.

Definition: The total number of new cases of hospital-acquired infection is a performance indicator that aggregates new cases of MRSA bacteremia, CDI, and VRE bacteremia into an overall performance measure. This case count excludes colonizations. New cases are tracked on a monthly basis for each category then added and averaged for each fiscal quarter.

Target: Target 11/12: 31

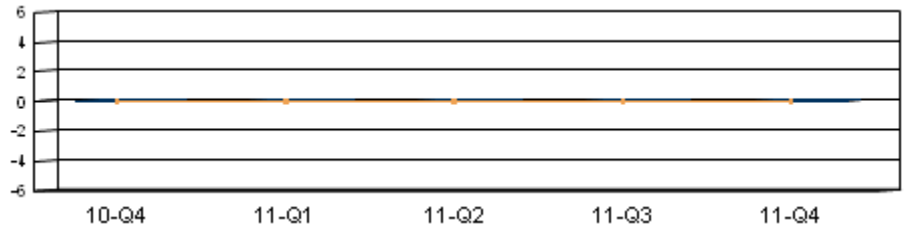
Kingston General Hospital

Milestone #5

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The number of new cases who acquire infections in our hospital is reduced by 10%

Indicator: Percent of Sepsis Cases Reviewed by Department Head



	Actual	Target
10-Q4	0	**0**
11-Q1	0	**0**
11-Q2	0	**0**
11-Q3	0	**0**
11-Q4	0	**0**

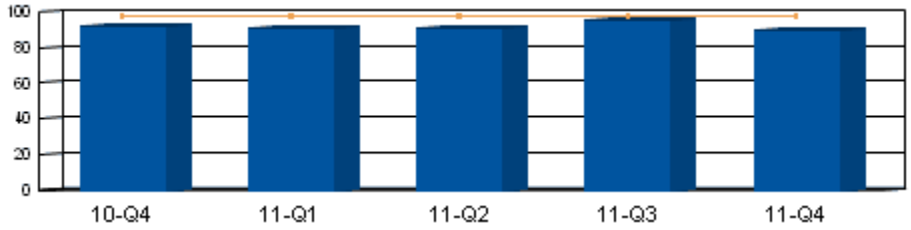
Interpretation - Patient And Business:

Not yet being reported. Expectation is in Q1 fiscal 12/13.

Definition: Quarterly review of all sepsis cases by Department heads and reported to the Medical Advisory Committee

Target: QIP Target 11/12: 75%

Indicator: Surgical Site Infection (SSI) Prevention



	Actual	Target
10-Q4	92	**97**
11-Q1	91	**97**
11-Q2	91	**97**
11-Q3	95	**97**
11-Q4	90	**97**

Interpretation - Patient And Business:

Patient perspective: The rate of appropriate timing of prophylactic antibiotic administration for patients undergoing orthopedic procedures slipped slightly in the last quarter but remains just above 90%. This reason for this is not readily apparent. Rates of surgical site infection post arthroplasty remain at acceptable levels.

Business perspective: Identification of other barriers to timely antibiotic administration is being examined by the Surgical Infection Control Working group.

Definition: Prevention of surgical site infections (SSI) is multi-faceted. One of the interventions used to reduce the incidence of SSI is the use of pre-operative antibiotics typically administered to patients 0 to 60 minutes (for usual antibiotics) or 0 to 120 minutes (for an antibiotic known as vancomycin) before they undergo surgery. This SSI-prevention indicator will report the percentage of time the health care team gave patients antibiotics within the appropriate time period before the surgery. This will be measured only in patients who are 18 years or older who are about to undergo primary hip or knee joint replacement surgery, including total, partial or hemi-arthoplasty.
Hospitals will post the percentage of hip/knee joint replacement surgical patients who received antibiotics within the appropriate time period before the surgery on their website every three months (quarterly), and will also report their data to the Ministry of Health and Long-Term Care through an online template captured by a central database. The Ministry will post this information on its public website.

Target: Target 09/10: 91.95%, Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: Provincial Avg. Or Better

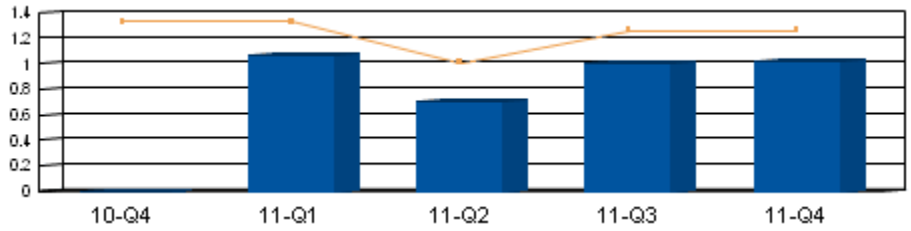
Kingston General Hospital

Milestone #5

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The number of new cases who acquire infections in our hospital is reduced by 10%

Indicator: Ventilator Associated Pneumonia



	Actual	Target
10-Q4	0.00	1.33
11-Q1	1.06	1.33
11-Q2	0.71	1.01
11-Q3	1.00	1.26
11-Q4	1.02	1.26

Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: Ventilator associated pneumonia (VAP) can occur in patients, specifically those in Intensive Care Units (ICU) who need assistance breathing with a mechanical ventilator for at least 48 hours. VAP case is defined as ICU patients 18 years and older who are on ventilators (occasionally or continuously) where Pneumonia appears at least 48 hours after the patient was placed on a ventilator.
Patients are at risk of acquiring VAP if they have been on a ventilator for more than 5 days, have been recently hospitalized, had prior use of antibiotics (within the last 90 days), had dialysis treatment in a clinic or resided in a nursing home.
The ministry will publicly report and post on its website by hospital site the number of VAP cases. Where the number is zero (0) or cases total five (5) or more associated with that hospital site, the number will be posted. If the cases are fewer than 5 (i.e., 1 to 4 cases), it will state "<5 cases", and the VAP rate (per 1000 ventilator days).

Target: Target 09/10: 3.01 Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: Provincial Avg. Or Better

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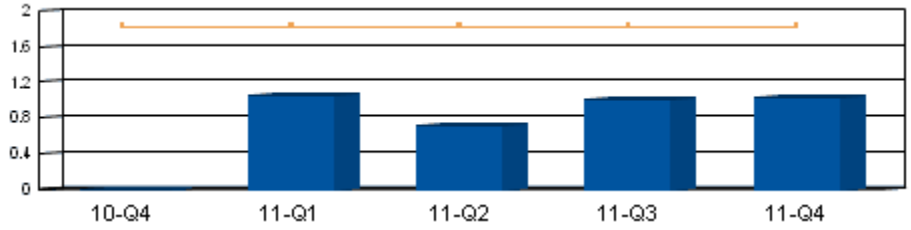
Indicator: Ventilator Associated Pneumonia (QIP)



	Actual	Target
10-Q4	0.00	1.82
11-Q1	1.06	1.82
11-Q2	0.71	1.82
11-Q3	1.00	1.82
11-Q4	1.02	1.82

Interpretation - Patient And Business:

Consistently below target for 7 quarters. Multi-pronged approach by ICU staff using VAP bundle and best practices monitored by a Patient Safety Coordinator continues to show success.

Actions & Monitoring Underway to Improve Performance:

Consistently below target for 7 quarters. Multi-pronged approach by ICU staff using VAP bundle and best practices monitored by a Patient Safety Coordinator continues to show success.

Definition: Ventilator associated pneumonia (VAP) can occur in patients, specifically those in Intensive Care Units (ICU) who need assistance breathing with a mechanical ventilator for at least 48 hours. VAP case is defined as ICU patients 18 years and older who are on ventilators (occasionally or continuously) where Pneumonia appears at least 48 hours after the patient was placed on a ventilator.
Patients are at risk of acquiring VAP if they have been on a ventilator for more than 5 days, have been recently hospitalized, had prior use of antibiotics (within the last 90 days), had dialysis treatment in a clinic or resided in a nursing home.
The ministry will publicly report and post on its website by hospital site the number of VAP cases. Where the number is zero (0) or cases total five (5) or more associated with that hospital site, the number will be posted. If the cases are fewer than 5 (i.e., 1 to 4 cases), it will state "<5 cases", and the VAP rate (per 1000 ventilator days).

Target: QIP Goal = 1.82, QIP Target For Compensation = 1.82

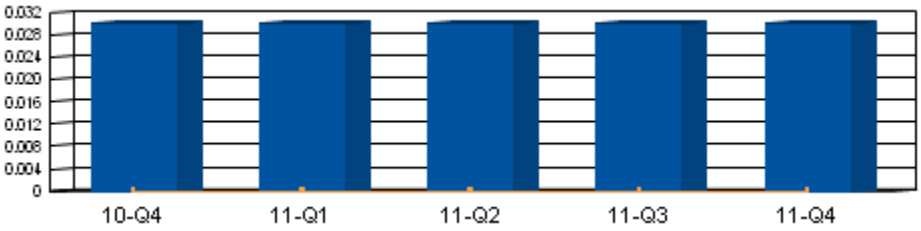
Kingston General Hospital

Milestone #5

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The number of new cases who acquire infections in our hospital is reduced by 10%

Indicator: VRE (Vancomycin-resistant Enterococcus)



	Actual	Target
10-Q4	0.03	**0**
11-Q1	0.03	**0**
11-Q2	0.03	**0**
11-Q3	0.03	**0**
11-Q4	0.03	**0**

Interpretation - Patient And Business:

Patient perspective: We continue to see rare isolated cases of VRE bacteremia amongst inpatients. We have very low rates of clinically relevant infection and no attributable mortality.

Business perspective: Main impact is on need to isolate patients who are colonized. Attendant isolation rates may have a direct impact on patient flow. No appreciable change in colonization rates for over 2 years suggests that VRE colonization is endemic in the community rather than solely the hospital. Options on the isolation of VRE colonized patients should be explored.

Definition: Enterococci are bacteria that live in the gastrointestinal tract of most individuals and generally do not cause harm. Vancomycin-resistant enterococci (VRE) are strains of enterococci that are resistant to the antibiotic vancomycin. If a person has an infection caused by VRE, such as a blood infection, it may be more difficult to treat due to the availability of antibiotics active against VRE.

KGH will post its quarterly rate and new case count of VRE bacteremia.
At the end of each quarter, the ministry will report the previous quarter's data on its website by hospital site including the number of new hospital acquired VRE bacteremia cases that is zero (0) or totaling five (5) or more associated with that hospital site, or if this is fewer than 5 cases (i.e. 1 to 4 cases), text reading "< 5 cases", and the hospital acquired VRE bacteremia rate.

The total number of new cases of VRE bacteremia acquired in the hospital in a quarter is divided by the total number of patient days for that quarter. Patient days are the number of days spent in a hospital for all patients. The results are multiplied by 1000. This represents the rate of hospital acquired VRE bacteraemia associated with the reporting facility per 1000 patient days for that quarter.

Target: Target 09/10: 0.0 Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: Provincial Avg. Or Better

Strategy milestone # 6

100% of our clinical services discharge patients at their expected LOS

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Transform the patient experience through a relentless focus on quality, safety and service	All preventable delays in the patient journey to, within, and from KGH are eliminated	Actively manage patient flow

Indicator(s)	Status
Overall - Acute Average Length of Stay vs. ELOS (Variance)	Green
Percent ALC Days	Green
Percent of Clinical Services Meeting ELOS Target	Red

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   Three of the six indicators reviewed in this milestone are green. Overall average length of stay is exceeding the ELOS by 0.5 of a day. Percent ALC days is at target of 10%. The average number of ALC patients per day has remained at 23 through Q3 and Q4. Of the 18 clinical services targeting to meet ELOS, 11 continue to be at or better than their ELOS and has kept the indicator red. The overall acute average length of stay has climbed by 0.3 of a day. The readmission rate within 30 days has fallen slightly to 17.4 days but remains above 4.5% above target.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Patent flow initiatives and physician engagement have created much of the gains on this indicator, CCAC resources and external supports such as rehabilitation beds are limited.

3. **Are we on track to meet the milestone by year end?**
   The ELOS indicator did not reach target and thus the milestone has not been met. Three of the 7 services not reaching their ELOS were out by only 0.3 days or less. The other services have a small foot print at KGH and one has significant manpower issues currently being addressed by SEAMO.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Patient and process review committees analyze roadblocks and focus on resolution. Patient Flow Task Force, Joint Program Council and the Most Responsible Physician Program are focused on these indicators and promoting engagement in ELOS targets.

Kingston General Hospital

Milestone #6

			10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	100% of our clinical services discharge patients at their expected LOS	Average # ALC Patients per Day	G	R	R	G	G	↑
		Overall - Acute Average Length of Stay Days (Based on HSAA)	Y	Y	G	Y	N/A	↓
		Overall - Acute Average Length of Stay vs. ELOS (Variance)	G	G	G	G	N/A	↑
		Percent ALC Days	R	Y	Y	G	N/A	↑
		Percent of Clinical Services Meeting ELOS Target	R	R	R	R	N/A	↓
		Readmission rate Within 30 Days for Selected CMG's	R	R	N/A	N/A	N/A	

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

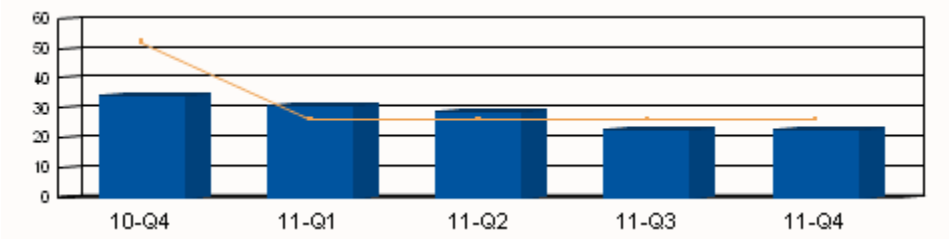
Kingston General Hospital

Milestone #6

SD1 Transform the patient experience through a relentless focus on quality, safety and service

100% of our clinical services discharge patients at their expected LOS

Indicator: Average # ALC Patients per Day



	Actual	Target
10-Q4	34	52
11-Q1	31	26
11-Q2	29	26
11-Q3	23	26
11-Q4	23	26

Interpretation - Patient And Business:

The Patient Flow Task Force will continue with oversight of the indicator. The Home First program remains a focus in all clinical areas with evidence of higher numbers of transfer to home. ALC rates, conversion rates and Home First trends are reviewed monthly with consideration of opportunities for improvement.

Partnering with Providence Care continues to enable assessment/designation of ALC in complex continuing care and rehab categories. Similar work is occurring with a focus on the mental health population (with Providence Care and Frontenac Community Mental Health and Addiction Services) and has been initiated with the long term care homes. Focus is on improvements with admission avoidance, transfer planning and communication at transition points.

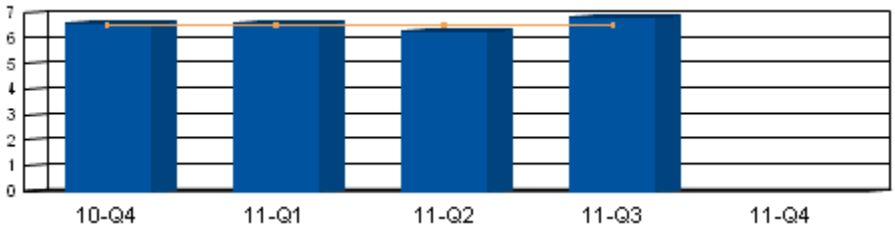
Actions & Monitoring Underway to Improve Performance:

Q4 results show this indicator continues to outperform the target. Focus will be on sustaining the impact of changes in internal processes and in process improvements with community partners that support transitions to home or alternate settings.

Definition: When a patient occupies a bed in a hospital and does not require the intensity of resources/services provided in the acute care setting, the patient must be designated Alternate Level of Care (ALC) by the physician or his/her delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination, or when the patient's needs or condition changes and the designation of ALC no longer applies.

Target: Baseline 08/09: 60 patients , Target 09/10: 57 patients, Target 10/11: 52 patients, Target 11/12: 26 patients.

Indicator: Overall - Acute Average Length of Stay Days (Based on HSAA)



	Actual	Target
10-Q4	6.6	6.5
11-Q1	6.6	6.5
11-Q2	6.3	6.5
11-Q3	6.8	6.5
11-Q4		

Interpretation - Patient And Business:

ALOS is the focus of work within programs, in the Patient Flow Task Force and at MAC. In addition, all programs are tasked with achieving the target of ELOS for their patient populations (ELOS is what would be expected length of stay for the type of patients at KGH).

Actions & Monitoring Underway to Improve Performance:

The average length of stay for Q3 has bumped up slightly to 6.8 days putting us .3 days above the target of 6.5 days. It is worth noting that at the same time are average length of stay compared is .6 days below our expected. So although our ALOS has jumped slightly we are remaining well below where we are expected to perform. There continues to be tremendous efforts placed on this achieving this target though the implementation of a variety of initiatives lead by a variety of disciplines.

Definition: This indicator is a measure of how long inpatients stay in-hospital. By measuring the "acute" length of stay, all alternate level of Care (ALC) days and any days of stay assigned to newborns are removed form the calculation. This is in keeping with MOH methodology and in support of comparing and benchmarking length of stay performance across hospitals. The length of stay is calculated by subtracting the day of admission from the day of discharge from hospital. For example if a patient is admitted on a Monday and discharged on a Friday, the length of stay would be 4 days. Length of stay a crude measure of efficiency as it relates the use of inpatient beds.

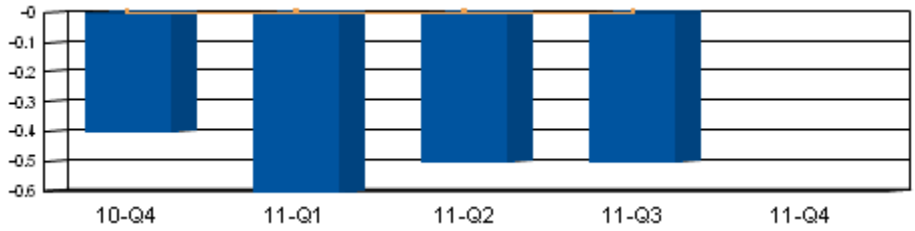
Target: Baseline 08/09: 6.8 days, Target 09/10: 6.5 days, Target 10/11: 6.5 days, Target 11/12: 6.5 days.

Milestone #6

SD1 Transform the patient experience through a relentless focus on quality, safety and service

100% of our clinical services discharge patients at their expected LOS

Indicator: Overall - Acute Average Length of Stay vs ELOS (Variance)



	Actual	Target
10-Q4	-0.4	**0**
11-Q1	-0.6	**0**
11-Q2	-0.5	**0**
11-Q3	-0.5	**0**
11-Q4		

Interpretation - Patient And Business:

Because this indicator is calculated using coded and abstracted medical record data, Q3 results are the latest complete fiscal quarter. A positive trend in overall performance continues although there has been some slight leveling off in Q3. The -0.5 variance for Q3 (fiscal 11/12) indicates that overall our actual length of stay remains below or better than our expected length of by 0.5 of a day. However, it is important to note that this is calculated on an overall basis. There remains opportunity to achieve expected length of stay in the services of Gastroenterology, Nephrology, Neurology, Neurosurgery, Obs/Gyn, Otolaryngology, and Plastic Surgery.

Actions & Monitoring Underway to Improve Performance:

Meetings through the Chief of Staff's office continue with individual Departments for the purpose of explaining these data and exploring opportunities for improvement. These data are also shared with all Program leadership for the purpose of exploring opportunities to improve length of stay.

Definition: This indicator is a measure of how long inpatients stay in-hospital. By measuring the “acute” length of stay, all alternate level of Care (ALC) days and any days of stay assigned to newborns are removed from the calculation. This is in keeping with MOH methodology and in support of comparing and benchmarking length of stay performance across acute care hospitals. The length of stay is calculated by subtracting the day of admission from the day of discharge from hospital. For example if a patient is admitted on a Monday and discharged on a Friday, the length of stay would be 4 days. Length of stay is a crude measure of efficiency as it relates the use of inpatient beds.
The expected length of stay (ELOS) is calculated on typical patients taking into account the reason for hospitalization, age, comorbidity, and complications. Typical cases exclude deaths, transfers, voluntary sign-outs, and cases where the actual length of stay is greater than the ""trim point"" established by CIHI. For this measure, a positive variance indicates actual days stay was longer than expected while a negative value suggests the average actual stay was shorter than expected.

Target: 11/12 Target: 0

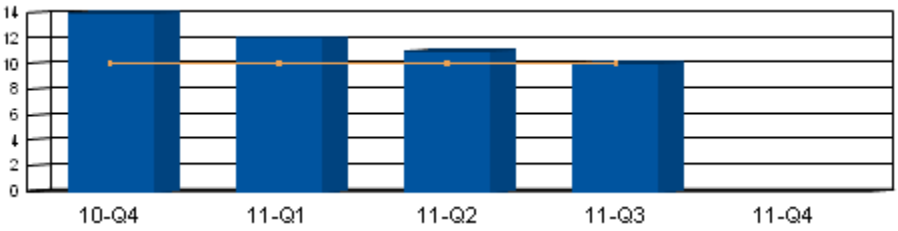
Kingston General Hospital

Milestone #6

SD1 Transform the patient experience through a relentless focus on quality, safety and service

100% of our clinical services discharge patients at their expected LOS

Indicator: Percent ALC Days



	Actual	Target
10-Q4	14	**10**
11-Q1	12	**10**
11-Q2	11	**10**
11-Q3	10	**10**
11-Q4		

Interpretation - Patient And Business:

The Patient Flow Task Force will continue with oversight of the indicator. The Home First program remains a focus in all clinical areas with evidence of higher numbers of transfer to home. ALC rates, conversion rates and Home First trends are reviewed monthly with consideration of opportunities for improvement.

Partnering with Providence Care continues to enable assessment/designation of ALC in complex continuing care and rehab categories. Similar work is occurring with a focus on the mental health population (with Providence Care and Frontenac Community Mental Health and Addiction Services) and has been initiated with the long term care homes. Focus is on improvements with admission avoidance, transfer planning and communication at transition points.

Actions & Monitoring Underway to Improve Performance:

This target has been achieved for the first time since this indicator was introduced. Because this is calculated using coded medical records data, it lags behind by one quarter hence; we are reporting Q3 results in Q4. The number of patients designated as ALC continues to decrease on a month by month basis, and the target for average number of ALC patients per day has been met in Q4 Focus remains on internal processes and process improvements with community partners that support transitions to home or alternate settings.

Definition: When a patient occupies a hospital bed and does not require the intensity of resources/services provided in the acute care setting, the patient must be designated alternate level of care (ALC) by the physician or his/her delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination, or when the patient's needs or condition changes and the designation of ALC no longer applies. The percent of ALC days (total ALC days/total inpatient days) is calculated to better understand the proportion of ALC days for a given period of time.

Target: 11/12 Target: 10%

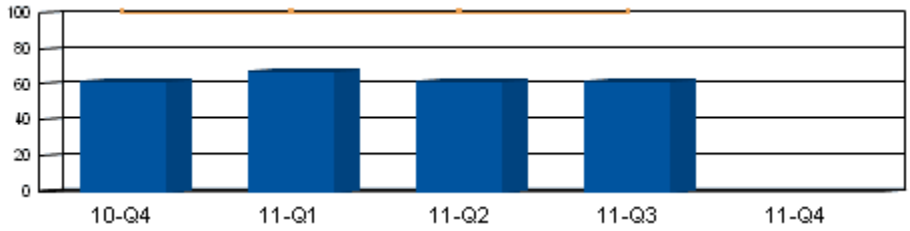
Kingston General Hospital

Milestone #6

SD1 Transform the patient experience through a relentless focus on quality, safety and service

100% of our clinical services discharge patients at their expected LOS

Indicator: Percent of Clinical Services Meeting ELOS Target



	Actual	Target
10-Q4	61	**100**
11-Q1	67	**100**
11-Q2	61	**100**
11-Q3	61	**100**
11-Q4		

Interpretation - Patient And Business:

Because this indicator is calculated using coded and abstracted medical record data, Q3 results (fiscal 11/12) are the latest complete quarter. 61 percent of services (11 of 18) are achieving (or outperforming) their expected length of stay. The services that are not currently at their expected length of stay are Gastroenterology, Nephrology, Neurology, Neurosurgery, Obs/Gyn, Otolaryngology, and Plastic Surgery. It is important to note that Gastroenterology and Obs and Gyn are out by only .2 of a day. Neurosurgery out by only .3 of a day.

Actions & Monitoring Underway to Improve Performance:

Meetings through the Chief of Staff's office continue with individual Departments on explaining these data and exploring opportunities for improvement. These data are also shared with all Program leadership for the purpose of exploring opportunities to improve length of stay.

Definition: "This indicator is a measure of how long inpatients stay in-hospital. By measuring the “acute” length of stay, all alternate level of Care (ALC) days and any days of stay assigned to newborns are removed from the calculation. This is in keeping with MOH methodology and in support of comparing and benchmarking length of stay performance across acute care hospitals. The length of stay is calculated by subtracting the day of admission from the day of discharge from hospital. For example if a patient is admitted on a Monday and discharged on a Friday, the length of stay would be 4 days. Length of stay is a crude measure of efficiency as it relates the use of inpatient beds.
The expected length of stay (ELOS) is calculated on typical patients taking into account the reason for hospitalization, age, comorbidity, and complications. Typical cases exclude deaths, transfers, voluntary sign-outs, and cases where the actual length of stay is greater than the ""trim point"" established by CIHI. For this measure, average acute length of stay is compared to ELOS at the clinical service level (e.g. cardiology, general surgery etc.). The services with a negative variance are tallied and divided by the total number of services expressed as a percent.
"

Target: QIP Target 11/12: 100%

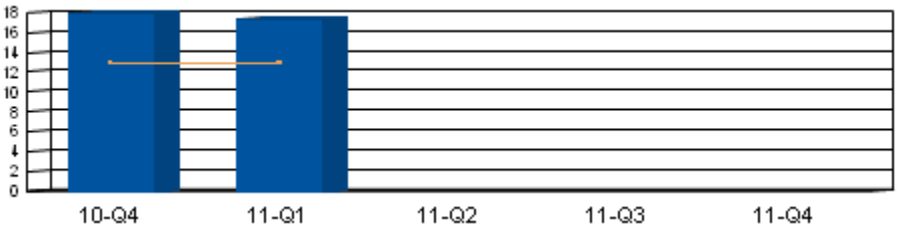
Kingston General Hospital

Milestone #6

SD1 Transform the patient experience through a relentless focus on quality, safety and service

100% of our clinical services discharge patients at their expected LOS

Indicator: Readmission rate Within 30 Days for Selected CMG's



	Actual	Target
10-Q4	17.9	**12.9**
11-Q1	17.4	**12.9**
11-Q2		
11-Q3		
11-Q4		

Interpretation - Patient And Business:

30 day readmission rates in part reflects that patients received appropriate, timely care from physicians, nurses and other healthcare providers. Another factor that may contribute to lower 30-day readmission rates is well-prepared instructions for discharge from the hospital. Examples include instructions on proper medication use, diet, wound care management and follow up instructions. Availability and access to CCAC/home care will play an additional role. This indicator represents the readmission rate for selected CMGs to ANY facility within the SE LHIN. A low rate of readmission would therefore be reflective of quality of care by the discharging institution and care provided in the community.

Actions & Monitoring Underway to Improve Performance:

These data are supplied to KGH from the MOH and generally are 3 quarters behind. The current rate is 17.4% (results from Q1 Fiscal 11/12) which is 4.5 percentage points above target of 12.9%. This is an improvement from the previous quarter. An in-depth analysis of each CMG group will be reviewed by MAC Joint Quality and Utilization Committee and the Patient Safety and Quality Committee. It is also worth noting that this indicator will be part of the KGH QIP for fiscal 12/13

Definition: This indicator is calculated by the MOH and supplied to KGH via the Ministry LHIN Performance agreement (MLPA – a performance agreement that focuses on system performance and financial accountabilities. This indicator is best described as the number of patients readmitted to any facility for non-elective inpatient care, compared to the number of expected non-elective readmissions using data from all Ontario acute hospitals. The number of patients readmitted to any facility for non-elective inpatient care is defined as the observed number of patients, discharged with specific CMG's within calendar year, readmitted to any facility for any non-elective patient care within the specified number days of discharge for index admission.

Target: QIP Goal 11/12= 12.9%

Strategy milestone # 7

The Emergency Department wait time for admitted patients is less than 8 hours for 100% of patients

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Transform the patient experience through a relentless focus on quality, safety and service	**All preventable delays in the patient journey to, within, and from KGH are eliminated**	**Reduce wait times**

Indicator(s)	Status
Percent of Patients Admitted (from the Emergency Department) Within a Wait Time Target of< 8 hrs	**Red**

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   The stretch target of all patients being admitted within 8 hours has not been met. The improvement with the majority of ED indicators continues.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The Patient Flow Task Force meets every 2 weeks with focus on multiple indicators related to access and length of stay. Use of the Code Gridlock twice in Q4 in response to total clinical congestion resulted in process improvements. Use of EDIS also enables sharing of objective detail about delays with consults, diagnostic testing, bed readiness, etc. and enables earlier discussion and decision making.

3. **Are we on track to meet the milestone by year end?**
   We did not meet the milestone by fiscal year end. There is however a general improvement in ED performance.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   The Patient Flow Task Force will continue with oversight of trends and making improvements to support movement into, through and from KGH. A revision of the gridlock protocol will support clinical teams being proactive with measures that the minimize delays with admissions, transfers and discharges. Implementation of discharge prediction is anticipated in Q1 of 2013.

Kingston General Hospital

Milestone #7

				10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	The ED wait time for admitted patients is less than 8 hrs for 100% of patients		90th Percentile ED Wait Time (All Admitted Patients)	R	G	G	G	G	↓
			Non-Admitted Patients with Minor or Uncomplicated Conditions in the Emergency Department (ED) - 90th percentile wait time (hrs)	R	R	R	R	R	↑
			Patients Admitted from the Emergency Department (ED) with Complex Conditions - 90th percentile wait time (hrs)	R	R	R	R	R	↓
			Percent of Non-Admitted High Acuity Patients Treated Within a Wait Time Target of <8hrs (CTAS 1-2) & <6hrs (CTAS 3)	R	G	G	G	G	↑
			Percent of Non-Admitted Low Acuity Patients (CTAS 4&5) Treated Within a Wait Time Target of <4hrs	R	R	R	R	R	↑
			Percent of Patients Admitted (from the Emergency Department) within a wait time target of <8 hrs	Y	G	Y	G	Y	↓
			Percent of Patients Admitted (from the Emergency Department) within a Wait Time Target of <8Hrs (SSC)	R	R	R	R	R	↓

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

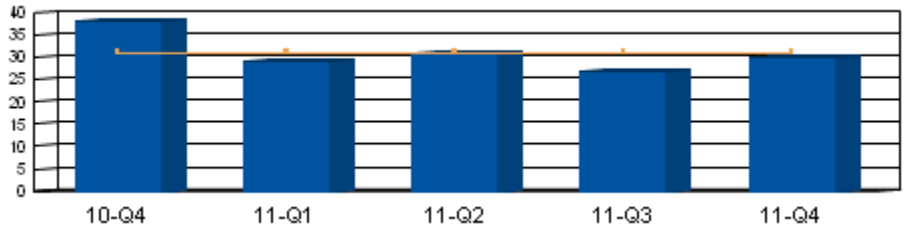
Kingston General Hospital

Milestone #7

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The ED wait time for admitted patients is less than 8 hrs for 100% of patients

Indicator: 90th Percentile ED Wait Time (All Admitted Patients)



	Actual	Target
10-Q4	38	**31**
11-Q1	29	**31**
11-Q2	31	**31**
11-Q3	27	**31**
11-Q4	30	**31**

Interpretation - Patient And Business:

The target of 9/10 patients spending less than 31 hours in the Emergency Department waiting for an inpatient bed has been met for the past 4 quarters. This is an improvement of 8 hours from Q4 last fiscal. At the end of Q4, 10% of admitted patients waited longer than 30.1 hours for an inpatient bed. This is a significant improvement given the increase in activity this year relative to last resulting in 453 more admissions in Q4 F12 than in Q4 F11.

Total admissions for F12 were 1350 over last fiscal and 2160 more than target.

Note: Year 4 Pay for Results target for this indicator is 33.2 hours & at Q2 the SE LHIN imposed an HSAA target of 25 hrs

Actions & Monitoring Underway to Improve Performance:

LOS in the ED is continuously monitored in real time with EDIS, and supports timely and factual communication with inpatient units to support planning.

A number of initiatives are in progress as part of the Ministry wait time project (Pay for Results) - ie Medical Short Stay Unit, additional express beds, Surgical Short Stay beds and a medicine nurse to coordinate patient flow to medicine units.
Consultant times are also being monitored from time of consult request to arrival in the ED and time of consult request to disposition decision. Changes with bed assignment process, ie Bed Allocator role and reporting/communication tools, continue to be monitored and improved.

Definition: This indicator measures the amount of time 9 out of 10 patients (90th percentile) spend in an ED being diagnosed, receiving treatment and waiting for admission to a hospital bed. Most patients spend less time, while 1 out of 10 patients will spend more time. The time being measured is defined as when a patient registers until the time when the patient is admitted to an inpatient hospital bed. For this indicator, 9 out of 10 patients (for all admitted patients at all levels of complexity) will spend no more than 31 hours within the ER from the time they arrive and register to the time they leave the ED.

Target: QIP Target 11/12: 31 Hours

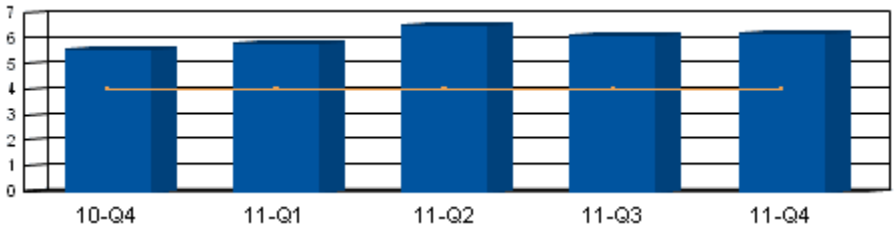
Kingston General Hospital

Milestone #7

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The ED wait time for admitted patients is less than 8 hrs for 100% of patients

Indicator: Non-Admitted Patients with Minor or Uncomplicated Conditions in the Emergency Department (ED) - 90th percentile wait time (hrs)



	Actual	Target
10-Q4	5.6	**4.0**
11-Q1	5.8	**4.0**
11-Q2	6.5	**4.0**
11-Q3	6.1	**4.0**
11-Q4	6.2	**4.0**

Interpretation - Patient And Business:

Patient Perspective: Based on the Q4 results, KGH is failing to meet the ED 90th percentile wait time target of 4hrs for patients presenting with minor or uncomplicated conditions. Ten percent of patients in this category had a total length of stay longer than 6.2 hours. The move of the MH inpatient unit in June (Q2) had a significant impact on the ED and at times limited our ability to see patients in fast track given the volumes patients requiring MH assessment and/or admission occupying the space used for fast track.

Visit volumes were significantly higher during Q4 with a higher proportion of high acuity patients requiring more urgent assessment and intervention (53% of all ED visits). Visits in this category (non-admit, low acuity) made up 24% of all ED visits.

Business Perspective: This is an indicator in the provincial Pay for Results program with a target of 4:52 hours at the 90th percentile. Funding is at risk of claw back if targets are not met. In addition, there is incentive pay through the provincial Pay for Results program for each patient in this low acuity non-admitted category seen and treated within the 4 hour target ($100 for each patient discharged within 4 hours over last year's baseline).

Actions & Monitoring Underway to Improve Performance:

Volumes have increased in the higher acuity category which means less acute patients may be waiting longer to be seen due to physician availability as they are busy with more urgent patients. In January, a new physician schedule started with additional coverage and overlap during peak times to help with Initial Physician Assessment times and to address wait times for patients in this category.

EDIS is helping to monitor turn-around times and alert physicians when results are ready for review.

Definition: This indicator measures the amount of time 9 out of 10 patients (90th percentile) spend in an ED being diagnosed, receiving treatment and being discharged from the ED. Most patients spend less time, while 1 out of 10 patients will spend more time. The time being measured is defined as when a patient registers until the time when the patient is discharged from the ED. 9 out of 10 patients whose conditions are minor or uncomplicated and require less time for treatment, diagnosis or observation will spend no more than 4 hours within the ER from the time they arrive and register to the time their visit is complete and they are discharged. CTAS (Canadian Triage & Acuity Scale) 4 or 5 are used to describe 'Minor or Uncomplicated'.

Target: Baseline 08/09: 7.0hrs, Target 09/10: 4hrs, Target 10/11: 4hrs, Target 11/12: 4hrs.

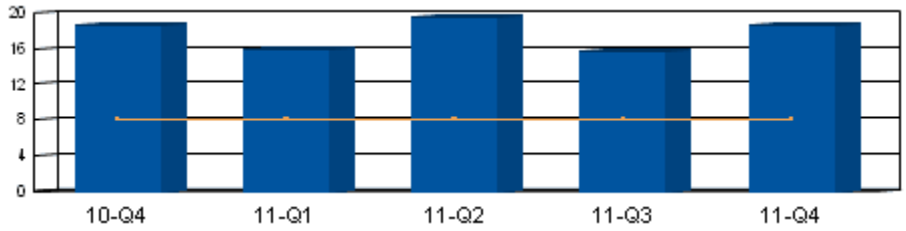
Kingston General Hospital

Milestone #7

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The ED wait time for admitted patients is less than 8 hrs for 100% of patients

Indicator: Patients Admitted from the Emergency Department (ED) with Complex Conditions - 90th percentile wait time (hrs)



	Actual	Target
10-Q4	18.7	8.0
11-Q1	15.8	8.0
11-Q2	19.6	8.0
11-Q3	15.7	8.0
11-Q4	18.7	8.0

Interpretation - Patient And Business:

Patient Perspective: Based on the Q4 results, KGH is failing to meet the 90th percentile total ED LOS target of 8 hours for admitted patients with complex conditions. There are quality of care and patient satisfaction concerns when patient's inpatient beds are not available once the decision to admit has been made. LOS in ED has reached over 3 days in this quarter. Nine of 10 patients were admitted to an inpatient bed within 18.7 hours, 3 hours longer than last quarter. Delays in moving patients include a high demand for critical care beds, particularly level 2 beds, mental health beds and increased isolation requirements.

Business Perspective: With increasing volumes and high acuity of patients presenting to the ED, the extended LOS of patients once admitted has a negative impact on the ED's ability to see and treat patients within target times. Volumes of admitted patients were 711 higher this quarter than expected and higher than in previous quarters particularly in the high acuity categories. Admitted patient volumes were 453 more in Q4 this fiscal than in Q4 last fiscal. Overall visit volumes were 10381 higher than the same quarter last fiscal. Admission rates average between 17.3 and 19.3% creating a surge in Medicine which was running at over 140% occupancy at times. Inefficiencies are created that have a negative financial impact on the hospital (e.g. caring for admitted patients in the Emergency Department during the most expensive part of their stay).

Actions & Monitoring Underway to Improve Performance:

Initiatives throughout the hospital and within each program are in progress to improve performance. e.g. medicine short stay unit, surgical short stay unit, express beds, offload nurse, EDIS, improved process for lab result notification, reduce bed empty time, medicine bed manager, and a change in process for placing patients with responsibility shifting to the Bed Allocators.

The Patient Flow Task Force (PFTF) meets every two weeks.

A drop in weekend discharges contributes to a bottleneck in the ED on Monday mornings and then the early part of the week is spent "catching up".

Often, patients do not get admitted until they have been in the ED longer than 8 hours meaning the breach occurs before the time of conversion from outpatient to inpatient. This often occurs when consults are not done in a timely fashion or there is a delay in the decision to admit. Consult times are now being tracked at 2 time stamps: time from consult request to the arrival of consultant service is the first time stamp and time from consult request to disposition decision is the second. These results are publicly reported.
7 short stay medicine beds were opened in July as well as surgical short stay beds to help decant patients out of the ED quicker. Additional express beds were opened to help manage higher volumes. The funding for these beds comes from the provincial Pay for Results program and funding is at risk of claw back if targets are not met.

Definition: This indicator measures the amount of time 9 out of 10 patients (90th percentile) spend in an ED being diagnosed, receiving treatment and waiting for admission to a hospital bed. Most patients spend less time, while 1 out of 10 patients will spend more time. The time being measured is defined as when a patient registers until the time when the patient is admitted to a hospital bed. 9 out of 10 patients with complex conditions that may require more time for treatment, diagnosis or admission to a hospital bed will spend no more then eight hours within the ER from the time they arrive and register to the time they leave the ER. CTAS (Canadian Triage & Acuity Scale) 1, 2 or 3 are used to describe 'Complex'.

Target: Baseline 08/09: 22.4hrs, Target 09/10: 8hrs, Target 10/11: 8hrs, Target 11/12: 8hrs.

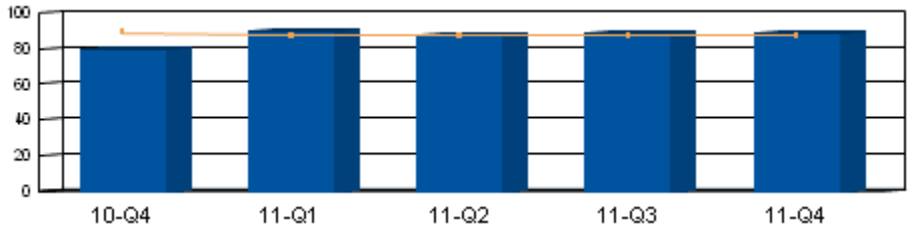
Kingston General Hospital

Milestone #7

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The ED wait time for admitted patients is less than 8 hrs for 100% of patients

Indicator: Percent of Non-Admitted High Acuity Patients Treated Within a Wait Time Target of <8hrs (CTAS 1-2) & <6hrs (CTAS 3)



	Actual	Target
10-Q4	80	**89**
11-Q1	90	**87**
11-Q2	87	**87**
11-Q3	88	**87**
11-Q4	88	**87**

Interpretation - Patient And Business:

Patient Perspective: Based on the Q4 results, the ED has improved the ED wait time surpassing the 87% target for non admitted, high acuity patients. Fewer non-admitted high acuity patients are waiting in the ED longer than the 8 and 6 hour targets compared to same time last year. Volumes for this category of patient increased by 1603 visits this fiscal over last.
This target has been achieved for the past 4 quarters.

Business Perspective: Year 4 Pay for Results funding enables us to implement initiatives to help with patient flow. This funding is at risk of claw back if targets are not met.

Note: The description of this indicator states CTAS 1 and 2 have an 8 hour target, while CTAS 3 has a 6 hour target. Under Pay for Results, this indicator has been changed to 7 hours for non-admitted high acuity. KGH has a target of 7:50 at the 90th percentile based on a ten per cent improvement over last year's baseline.

Actions & Monitoring Underway to Improve Performance:

Initiatives are in progress to meet and sustain gains made with respect to this target e.g. improved lab result notification, improvement of the Fast Track to include ambulatory CTAS 3 patients, realignment of medical coverage in the ED to patient arrival times as well as additional physician hours with overlapping shifts to cover busier times. A triage transition nurse assignment supports 90 second straight back triage and will help to ensure triage is quick and patients in this category are brought to a stretcher for more rapid assessment and treatment.

A dedicated off-load nurse helps to ensure patients arriving by ambulance do not wait to be "off-loaded" and are assessed by this nurse upon arrival. Average off-load time this quarter is 8 minutes.

Color coding on EDIS alerts staff if patients are approaching target time.

We have been green in each quarter this fiscal.

Definition: There are three Emergency Department (ED) wait time metrics that are directly tied to the Provincial ED Pay for Results initiative which is focused on reducing ED wait times. Each metric is designed to focus on a particular cohort of patients that present to the ED and each one has been assigned a target. The MOH provided selected hospital with funding to support initiatives aimed at improving patient flow. This measure represents the percentage of non-admitted high acuity patients treated within a wait time target of less than 8hrs (CTAS 1-2) and less than6hrs (CTAS 3). The 8 and 6 hour wait time targets are measured from the time of registration in ED to the time the patient leaves the ED.

(Note: CTAS – the Canadian Triage Acuity Scale and is a 5 level scale – level 1 being the most acute and level 5 the least acute).

Target: Baseline 08/09: 77%, Target 09/10: 87%, Target 10/11: 89%, Target 11/12: 87%

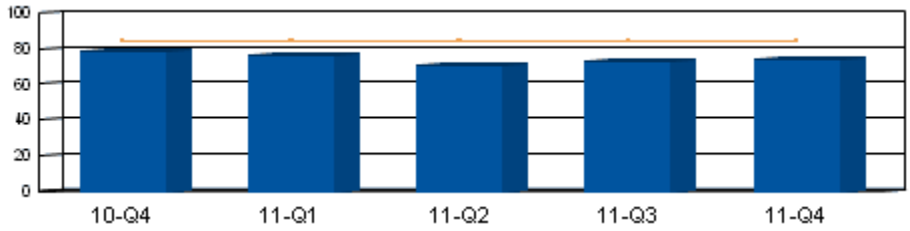
Kingston General Hospital

Milestone #7

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The ED wait time for admitted patients is less than 8 hrs for 100% of patients

Indicator: Percent of Non-Admitted Low Acuity Patients (CTAS 4&5) Treated Within a Wait Time Target of <4hrs



	Actual	Target
10-Q4	78	**84**
11-Q1	76	**84**
11-Q2	71	**84**
11-Q3	73	**84**
11-Q4	74	**84**

Interpretation - Patient And Business:

Patient Perspective: Based on Q4 results the ED is failing to meet the target wait time for the non-admitted low acuity patients. 26% of patients in this category have an ED total LOS greater than 4 hours. This is due to the large volumes of higher acuity patients and number of ambulances. Many of the patients in this category could be seen in the fast track area which sometimes is full with other patients requiring this space. Ie, because the rooms in this section have doors, they are often used for patients requiring mental health assessment.

High volumes of patients with higher acuity means that patients in this category wait longer for physician assessment, diagnosis and treatment.

Business Perspective: This target is associated with Pay for Results funding but funding is not solely dependent on this indicator.

Implementation of the EDIS in March 2011 is helping to monitor turn-around time for test results and promote timelier reassessment.

Volumes in this category were slightly higher than planned.

Actions & Monitoring Underway to Improve Performance:

The creation of an e-track in section E was open daily from 0800 to 2000. Most days 50% of all patients presenting to the ED were seen in etrack which had significantly contributed to the trend toward meeting this target in F11. When the inpatient Mental Health Program moved to KGH in June, Section E was modified to be used for MH patients. The fast-track was then moved to Section B. At first this was successful, however, after MH volumes started to increase, there was an overflow of patients from section E to B. As well, Section E is only staffed 8 hours a day. This has had a negative impact on our ability to see patients in this category due to lack of space. An increase in higher acuity volumes combined with the number of admitted patients waiting for beds has forced more patients to wait in the waiting room for a space to become available for further assessment and treatment.

The implementation of the Emergency Department Information System (EDIS) will help us to continuously monitor ED wait times in real time.

Definition: There are three ED wait time metrics that are directly tied to the Provincial ED Pay for Results initiative which is focused on reducing ED wait times. The MoH provides financial support to select hospitals to improve on ED wait times – decreasing ED demand, increasing ED capacity and improving bed utilization.
This measure represents the percentage of non-admitted low acuity patients treated within a wait time target of less than 4hrs (CTAS 4 & 5). The 4 hour wait time target is measured from the time of registration in ED to the time the patient leaves the ED.

(Note: CTAS – the Canadian Triage Acuity Scale and is a 5 level scale – level1 being the most acute and level 5 the least acute).

Target: Baseline 08/09: 66%, Target 09/10: 76%, Target 10/11: 84%, Target 11/12: 84%.

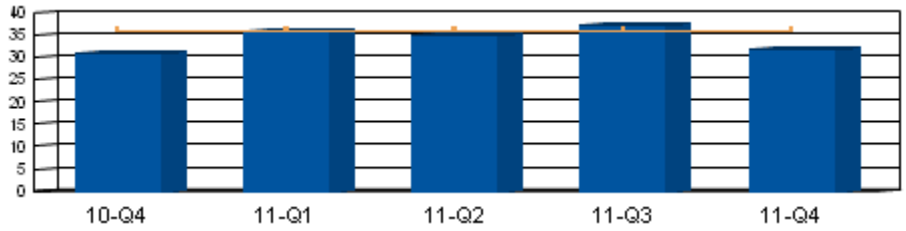
Kingston General Hospital

Milestone #7

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The ED wait time for admitted patients is less than 8 hrs for 100% of patients

Indicator: Percent of Patients Admitted (from the Emergency Department) within a wait time target of <8 hrs



	Actual	Target
10-Q4	31	**36**
11-Q1	36	**36**
11-Q2	35	**36**
11-Q3	37	**36**
11-Q4	32	**36**

Interpretation - Patient And Business:

Patient Perspective: Based on Q4 results, improvements to patient flow have been made over this past year. This target was met in Q1 and Q3 and missed by only 1 percentage point in Q2. While most patients are waiting longer than 8 hours before reaching their inpatient bed, 32% are moving within the 8 hour target.
Those that wait longer than 8 hours are waiting 18.7 hours at the 90th percentile. Inpatient days in ED this quarter were 602 days which is 110 days less than the previous quarter.

Business Perspective: When the ED becomes backed up with admitted patients it negatively impacts the ability to see and treat emergency patients from a space and resource perspective. The number of patients admitted requiring specialized services, i.e. isolation, critical care and mental health, limits the ability to quickly move these patients to an inpatient bed if these specialized beds are not available.

Funding from the provincial Pay for Results program will enable us to continue with initiatives in place to sustain gains made and continue to improve patient flow. This target is now measured at the 90th percentile under the provincial program with a target of 33.2 hours based on a 10% improvement over last year's baseline.

Actions & Monitoring Underway to Improve Performance:

KGH continues to be part of the Provincial Pay for Results Program for the 4th consecutive year. Additional flex capacity has been built in with the opening of 7 new short stay medicine beds in July (express beds). These beds are funded under the provincial pay for results program. Funding is at risk if targets are not met.

Clinical teams are engaged in planning discharges from the point of admission; and making changes with prediction of discharge dates and activation of conditional discharge orders at earliest point in the day with goal of having discharges occur as quickly as possible after the order is written.

Some patients do not get admitted until after the 8 hour target has passed for various reasons including long waits for consult or a delay in the decision to admit. This time from consult request to consultant arrival in ED as well as the time from consultant request to disposition decision is now being measured, monitored and publicly reported.

A drop in the number of discharges occurring on the weekends causes predictable bottlenecks in ED on Monday mornings. The early part of the week is spent "catching up".

Definition: This is the length of time a patient admitted to hospital is in the ED waiting for an inpatient bed The MoH provides financial support to select hospitals to improve on ED wait times – decreasing ED demand, increasing ED capacity and improving bed utilization. This measure represents the percentage of admitted patients (from the ED) with a length of stay LOS of <8 hrs. The 8 hours is measured from the time the patient is registered in the ED to the time that the patient is moved into an inpatient bed.

Target: Baseline 08/09: 27%, Target 09/10: 37%, Target 10/11: 36%, Target 11/12: 36%.

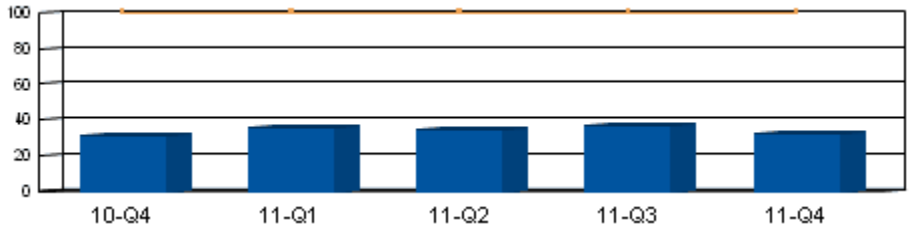
Kingston General Hospital

Milestone #7

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The ED wait time for admitted patients is less than 8 hrs for 100% of patients

Indicator: Percent of Patients Admitted (from the Emergency Department) within a Wait Time Target of <8Hrs (SSC)



	Actual	Target
10-Q4	31	**100**
11-Q1	36	**100**
11-Q2	35	**100**
11-Q3	37	**100**
11-Q4	32	**100**

Interpretation - Patient And Business:

KGH is not meeting the 100 percent target set by KGH. In order to meet these target significant improvements in the movement of admitted patients from the ED to inpatient units must occur.
Many patients require longer than 8 hours for assessment, consultation and decision to admit. For these patients, it is reasonable to expect a LOS greater than 8 hours in the ED.

Actions & Monitoring Underway to Improve Performance:

All additionally funded beds have been opened included short stay beds in both Medicine and Surgery, express beds and flex capacity has been created.
Surgery has closed appropriate beds reflective of LOS targets. LOS continues to be monitored.
Staffing the flex beds and overcapacity beds has been challenging and has contributed to delays in moving patients to these beds. Surges in Medicine, Critical Care (level 2) and Mental Health all contribute to challenges with bed availability.
Exploring opportunities to create a "direct to service" assessment unit outside of the ED.

Definition: This is the length of time a patient admitted to hospital is in the ED waiting for an inpatient bed The MoH provides financial support to select hospitals to improve on ED wait times – decreasing ED demand, increasing ED capacity and improving bed utilization. This measure represents the percentage of admitted patients (from the ED) with a length of stay LOS of <8 hrs. The 8 hours is measured from the time the patient is registered in the ED to the time that the patient is moved into an inpatient bed.

Target: SSC Target 100%

Strategy milestone # 8

90% of patients receive their elective surgery within or faster than the provincially targeted wait time

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Transform the patient experience through a relentless focus on quality, safety and service	All preventable delays in the patient journey to, within, and from KGH are eliminated	Reduce wait times

Indicator(s)	Status
Percent of Total Surgical Wait Times Meeting or Exceeding 90th Percentile Wait Time Targets	Red

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   At Q4, 32 of 44 (73%) of surgical wait times being followed met or exceeded the 90th percentile target. There were 4 in General Surgery (non cancer), 1 in pediatric Oral/Maxillofacial surgery, 3 in Orthopedics (non joint), 2 in Plastic Surgery and 2 in Urology (non cancer).

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Contributing factors include competing priorities within programs (e.g.. cancer vs. non cancer), wait list management, system operational efficiencies. MRI wait times are improving and a recent recruitment will improve this indicator.

3. **Are we on track to meet the milestone by year end?**
   The target of 90% for Q4 and year end was not met.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   The surgical program leadership closely monitors all wait times with the Wait Times Committee. Individual Departments and Divisions are informed of their rates and encouraged to develop means to reduce waiting times.

Kingston General Hospital

Milestone #8

				10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	90% of patients receive their elective surgery within or faster than the provincially targeted wait time		All Cancer Surgery Wait time - 90th Percentile Wait Time (Days)	G	G	G	G	G	↓
			All Paediatric Surgery - 90th Percentile Wait Time (Days)	R	R	R	R	R	↑
			Cardiac Bypass Surgery - 90th Percentile Wait Time (Days)	G	G	G	G	G	↑
			Coronary Angiography - 90th Percentile Wait Time (Days)	G	G	G	G	G	↑
			Coronary Angioplasty - 90th Percentile Wait Time (hrs)	G	G	G	G	G	↑
			Diagnostic Imaging - CT – 90th Percentile Wait time (Days)	G	G	G	G	G	↓
			Diagnostic Imaging- MRI – 90th Percentile Wait time (Days)	R	R	R	R	R	↑
			General Surgical Procedures (Excluding Confirmed and Suspected Cancer Surgeries) - 90th Percentile Wait Time (Days)	G	G	G	R	R	↓
			Orthopedic Hip and Knee Replacement Surgery - 90th Percentile Wait Time (Days)	G	G	G	G	G	↑
			Orthopedic Surgery (excluding total hip and knee replacements) - 90th Percentile Wait Time (Days)	R	R	R	R	R	↑
			Percent of Total Surgical Wait Times Meeting or Exceeding 90th Percentile Wait Time Targets	R	R	R	R	R	↓
			Radiation Wait time (Referral-Consult) Percent seen within 14 days	G	G	R	R	N/A	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

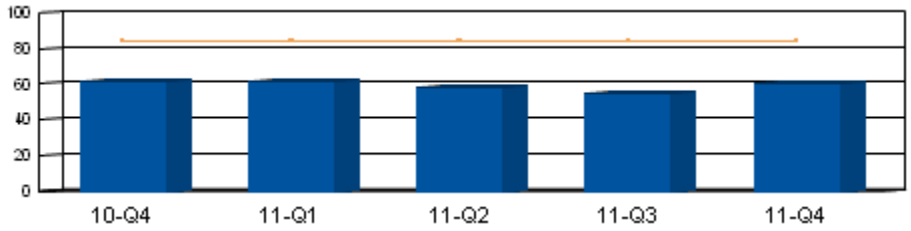
Kingston General Hospital

Milestone #8

SD1 Transform the patient experience through a relentless focus on quality, safety and service

90% of patients receive their elective surgery within or faster than the provincially targeted wait time

Indicator: All Cancer Surgery Wait time - 90th Percentile Wait Time (Days)



	Actual	Target
10-Q4	62	84
11-Q1	61	84
11-Q2	58	84
11-Q3	55	84
11-Q4	60	84

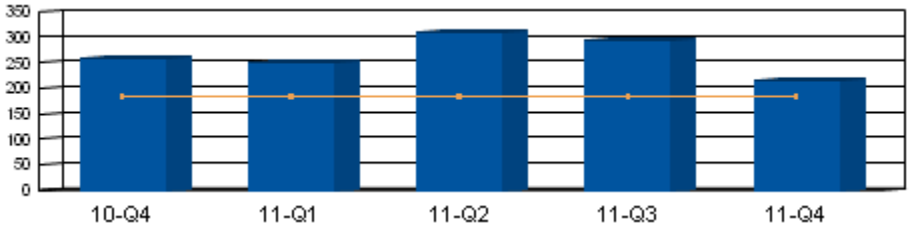
Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: For all confirmed and suspected cancer surgical procedures, Cancer Care Ontario and the Ontario WTS measures the wait time from when a patient and surgeon decide to proceed with surgery, until the time when the actual surgical procedure is completed. This interval is typically referred to as from "decision to treat" to "treatment". For wait times that are reported for the specific time period, calculations include all cases where the surgery or exam ("treatment") was completed during that time period. The wait times are calculated by subtracting the "decision to treat" date from the "treatment" date, resulting in a wait time that is measured in days. The wait is calculated for each patient who received treatment within the most current time period, for a particular service area and hospital. The 90th percentile wait time is defined as the point at which 9 out of 10 patients have completed surgery.

Target: Baseline 08/09: 64 days, Target 09/10: 84 days, Target 10/11: 84 days, Target 11/12: 84 days.

Indicator: All Paediatric Surgery - 90th Percentile Wait Time (Days)



	Actual	Target
10-Q4	258	182
11-Q1	250	182
11-Q2	310	182
11-Q3	293	182
11-Q4	217	182

Interpretation - Patient And Business:

KGH has not achieved the 90th percentile wait time provincial target for Q4.although the 90th percentile wait has improved by 76 days from Q3. The 90% for ENT in this final quarter had the highest wait time in February with 1063 days which then decreased to 657 days in March. The ENT service average median is 66 days in Q4 which is a significant improvement of 74 days from Q3. There continually is a challenge with the reduced physician resources for this service which impacts the number of Otolaryngology patient with long waits receiving surgery.

Pediatric general surgery does not impact this data as the case volumes remain small for the 2 part-time physicians currently in place.

Actions & Monitoring Underway to Improve Performance:

Program leadership has concluded a review of wait time list coding with these services and support program resources are being trained and implemented to also assist services with monitoring for next quarter.

Definition: For children 18 years and under having surgical procedures, the Ontario WTS measures the wait time from when a patient and a surgeon decide to proceed with surgery, until the time when the actual surgical procedure is completed. This interval is typically referred to as from "decision to treat" to "treatment". For wait times that are reported for the specific time period, calculations include all cases where the surgery ("treatment") was completed during that time period. The wait times are calculated by subtracting the "decision to treat" date from the "treatment" date, resulting in a wait time that is measured in days. The wait is calculated for each patient who received treatment within the most current time period, for a particular service area and hospital. The 90th percentile wait time is defined as the point at which 9 out of 10 patients have completed surgery.

Target: Target 09/10: 182 days, Target 10/11: 182 days, Target 11/12: 182 days.

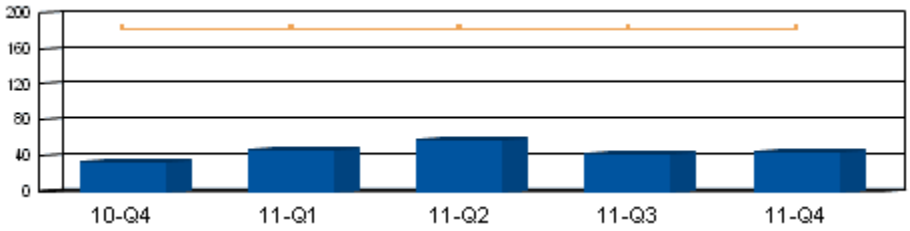
Kingston General Hospital

Milestone #8

SD1 Transform the patient experience through a relentless focus on quality, safety and service

90% of patients receive their elective surgery within or faster than the provincially targeted wait time

Indicator: Cardiac Bypass Surgery - 90th Percentile Wait Time (Days)



	Actual	Target
10-Q4	33	182
11-Q1	46	182
11-Q2	57	182
11-Q3	43	182
11-Q4	45	182

Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: For cardiac surgeries, the Ontario Wait Time Strategy (WTS) measures the wait time from when a patient and surgeon decide to proceed with surgery, until the time when the actual surgical procedure is completed. This interval is typically referred to as from "decision to treat" to "treatment". For wait times that are reported for the specific time period, calculations include all cases where the surgery or ("treatment") was completed during that time period. The wait times are calculated by subtracting the "decision to treat" date from the "treatment" date, resulting in a wait time that is measured in days. The wait is calculated for each patient who received treatment within the most current time period, for a particular service area and hospital. The 90th percentile wait time is defined as the point at which 9 out of 10 patients have completed surgery.

Target: Baseline 08/09: 78 days, Target 09/10: 182 days, Target 10/11: 182 days, Target 11/12: 182 days

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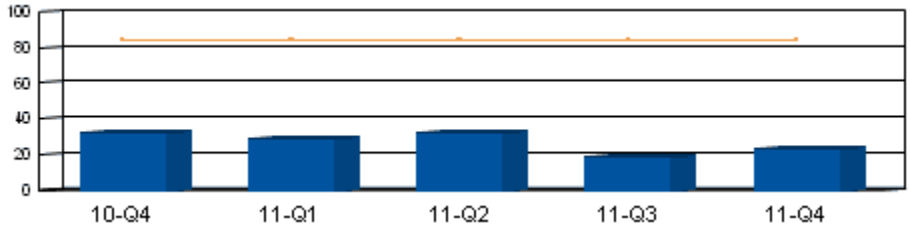
Indicator: Coronary Angiography - 90th Percentile Wait Time (Days)



	Actual	Target
10-Q4	32	84
11-Q1	29	84
11-Q2	32	84
11-Q3	19	84
11-Q4	23	84

Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: Coronary angiography means taking pictures of blood vessels in the heart. Angiography involves injecting a dye that is visible to x-rays. The physician, a cardiology interventionalists, uses an x-ray machine to guide him or her through the procedure and record the pictures. For coronary angiography procedures, the Ontario Wait Time Strategy (WTS) measures the wait time from when a patient and interventionalist decide to proceed with the procedure, until the time when the actual procedure is completed. This interval is typically referred to as from "decision to treat" to "treatment". For wait times that are reported for the specific time period, calculations include all cases where the procedure or ("treatment") was completed during that time period. The wait times are calculated by subtracting the "decision to treat" date from the "treatment" date, resulting in a wait time that is measured in days. The wait time is calculated for each patient who received treatment within the most current time period, for a particular service area and hospital. The 90th percentile wait time is defined as the point at which 9 out of10 patients have completed the treatment. .
Note: Wait Time information is shown only for referrals where the primary indication is coronary artery disease. These account for >85% of total angiography referrals.

Target: Baseline 08/09: 39 days, Target 09/10: 84 days, Target 10/11: 84 days, Target 11/12: 84 days.

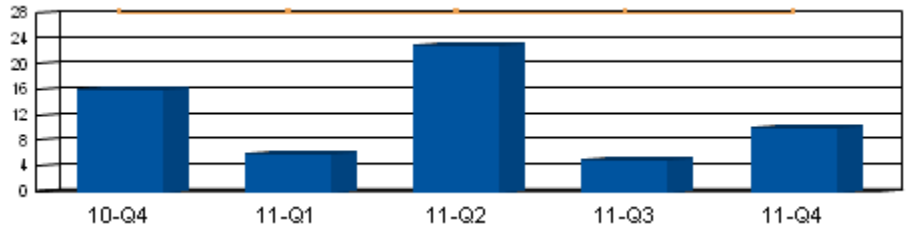
Kingston General Hospital

Milestone #8

SD1 Transform the patient experience through a relentless focus on quality, safety and service

90% of patients receive their elective surgery within or faster than the provincially targeted wait time

Indicator: Coronary Angioplasty - 90th Percentile Wait Time (hrs)



	Actual	Target
10-Q4	16	28
11-Q1	6	28
11-Q2	23	28
11-Q3	5	28
11-Q4	10	28

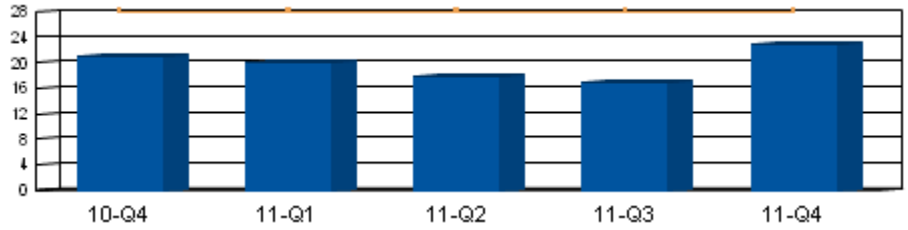
Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: Coronary angioplasty is a procedure which unblocks narrowed arteries by inserting a small balloon into each artery and inflating the balloon at the site of the blockage. Often, a small metal tube (stent) is permanently placed in the artery to help keep the artery open. This allows blood to flow freely through the artery. For coronary angioplasty procedures, the Ontario Wait Time Strategy (WTS) measures the wait time from when a patient and interventional cardiologist decide to proceed with the procedure, until the time when the actual procedure is completed. This interval is typically referred to as from "decision to treat" to "treatment". For wait times that are reported for the specific time period, calculations include all cases where the procedure or ("treatment") was completed during that time period. The wait times are calculated by subtracting the "decision to treat" date from the "treatment" date, resulting in a wait time that is measured in days. The wait is calculated for each patient who received treatment within the most current time period, for a particular service area and hospital. The 90th percentile wait time is defined as the point at which 9 out of10 patients have completed the treatment.

Target: Baseline 08/09: 12 days, Target 09/10: 28 days, Target 10/11: 28 days, Target 11/12: 28 days.

Indicator: Diagnostic Imaging - CT – 90th Percentile Wait time (Days)



	Actual	Target
10-Q4	21	28
11-Q1	20	28
11-Q2	18	28
11-Q3	17	28
11-Q4	23	28

Interpretation - Patient And Business:

KGH continues to meet targets. The department is designed to meet the needs of the emergency department, the inpatient population and specialty CT studies.

We monitor these wait times on a weekly basis within the Imaging department and they are monitored monthly by Decision Support. Action is taken to deal with any increases in wait times when they occur.

Immediate access to the CT is imperative for ER and acute inpatient cases. Driving this number as low as possible is a goal the must be monitored constantly.

Definition: For diagnostic CT scans, the Ontario Wait Time Strategy measures the wait time from when a CT scan is ordered, until when the actual exam is completed. This interval is typically referred to as from "decision to treat" to "treatment". A patient with an existing condition may be pre-booked for a follow-up exam or a series of follow-up exams at a later date, resulting in apparently long wait times for those particular exams. Please note, as of January 1st, 2008 these cases are excluded from publically reported CT wait time data as well scans done on an emergency basis. The 90th percentile wait time is defined as the point at which 9 out of 10 patients have completed the exam.

Target: Baseline 08/09: 26 days, Target 09/10: 28 days, Target 10/11: 28 days, Target 11/12: 28 days.

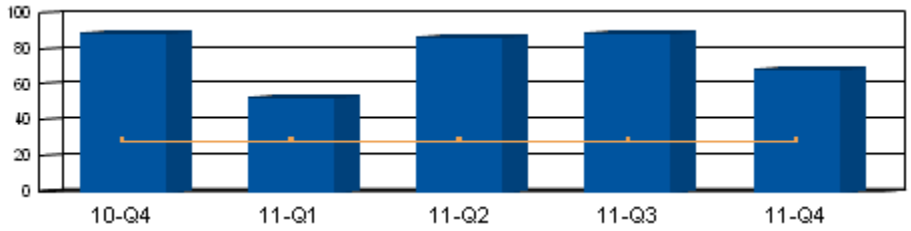
Kingston General Hospital

Milestone #8

SD1 Transform the patient experience through a relentless focus on quality, safety and service

90% of patients receive their elective surgery within or faster than the provincially targeted wait time

Indicator: Diagnostic Imaging- MRI – 90th Percentile Wait time (Days)



	Actual	Target
10-Q4	89	28
11-Q1	53	28
11-Q2	86	28
11-Q3	88	28
11-Q4	68	28

Interpretation - Patient And Business:

The demand on the MRI is much larger than the resources available to accommodate the patient load. A single magnet is unable to effectively manage all the specialty driven studies required at KGH. Extended hours have been implemented and 5th full time technologist is being recruited to maximize the workload that cane performed in a day on a single magnet. When possible, non-complex cases are forwarded to the private clinic within the city. The booking schedule is constantly reviewed to maximize utilization of the magnet. Protocols are being reviewed by the radiologists to determine whether some can be shortened therefore decreasing the length of time a case has to be in the magnet which would increase the number of cases performed in a day.

Delays in accessing the MRI delays patient care and decision making on the part of the healthcare providers. This is frustrating for the ordering physicians and causes the patients and their family anxiety waiting to access the MRI for a procedure that might be required before a definitive diagnosis is made.

Definition: For diagnostic MRI scans, the Ontario Wait Time Strategy measures the wait time from when a diagnostic scan is ordered, until when the actual exam is completed. This interval is typically referred to as from "decision to treat" to "treatment". A patient with an existing condition may be pre-booked for a follow-up exam or a series of follow-up exams at a later date, resulting in apparently long wait times for those particular exams. Please note, as of January 1st, 2008 these cases are excluded from publically reported MRI wait time data as well scans done on an emergency basis. The 90th percentile wait time is defined as the point at which 9 out of 10 patients have completed the exam.

Target: Baseline 08/09: 120 days, Target 09/10: 28 days, Target 10/11: 28 days, Target 11/12: 28 days

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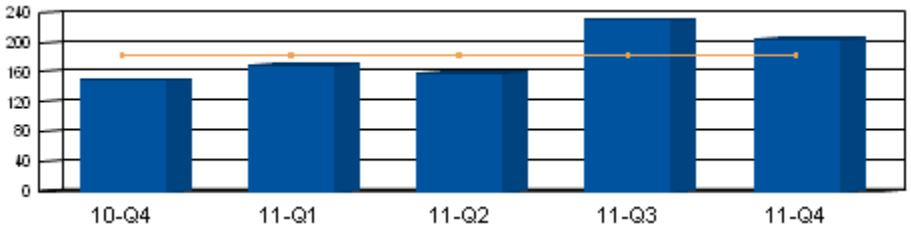
Indicator: General Surgical Procedures (Excluding Confirmed and Suspected Cancer Surgeries) - 90th Percentile Wait Time (Days)



	Actual	Target
10-Q4	149	182
11-Q1	169	182
11-Q2	159	182
11-Q3	230	182
11-Q4	204	182

Interpretation - Patient And Business:

The 90th percentile wait time for this service improved by 26 days in this final quarter which is trending again in a positive direction, Tithe median wait for Q4 was 69 days, a slight increase of 11 days from Q3 however this includes the completion of 7 cases which ranged from 241 to 945 days on the waiting list.

Actions & Monitoring Underway to Improve Performance:

Currently this service has access to additional OR time during the evening and on weekends to add any elective cases once the trauma cases are addressed to assist with reducing long wait time cases. The Program is working with the service by supporting additional monitoring resources for wait time lists.

Definition: For all general surgical procedures (excluding confirmed and suspected cancer surgeries), the Ontario WTS measures the wait time from when a patient and a surgeon decide to proceed with surgery, until the time when the actual surgical procedure is completed. This interval is typically referred to as from "decision to treat" to "treatment". For wait times that are reported for the specific time period, calculations include all cases where the surgery ("treatment") was completed during that time period. The wait times are calculated by subtracting the "decision to treat" date from the "treatment" date, resulting in a wait time that is measured in days. The wait is calculated for each patient who received treatment within the most current time period, for a particular service area and hospital. The 90th percentile wait time is defined as the point at which 9 out of 10 patients have completed surgery.

Target: Baseline 08/09: 306 days, Target 09/10: 182 days, Target 10/11: 182 days, Target 11/12: 182 days.

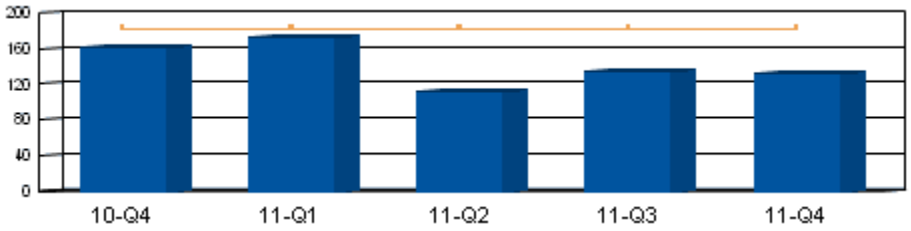
Kingston General Hospital

Milestone #8

SD1 Transform the patient experience through a relentless focus on quality, safety and service

90% of patients receive their elective surgery within or faster than the provincially targeted wait time

Indicator: Orthopedic Hip and Knee Replacement Surgery - 90th Percentile Wait Time (Days)



	Actual	Target
10-Q4	161	182
11-Q1	173	182
11-Q2	111	182
11-Q3	135	182
11-Q4	132	182

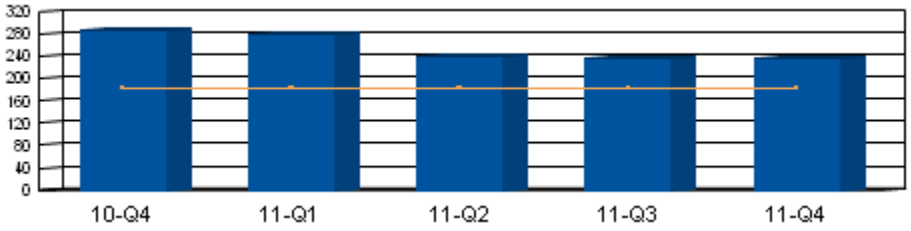
Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: For all total hip and knee replacement procedures, the Ontario WTS measures the wait time from when a patient and surgeon decide to proceed with surgery, until the time when the actual surgical procedure is completed. This interval is typically referred to as from "decision to treat" to "treatment". For wait times that are reported for the specific time period, calculations include all cases where the surgery or ("treatment") was completed during that time period. The wait times are calculated by subtracting the "decision to treat" date from the "treatment" date, resulting in a wait time that is measured in days. The wait is calculated for each patient who received treatment within the most current time period, for a particular service area and hospital. The 90th percentile wait time is defined as the point at which 9 out of 10 patients have completed surgery.

Target: Baseline 08/09: 403 days, Target 09/10: 182 days, Target 10/11: 182 days, Target 11/12: 182 days.

Indicator: Orthopedic Surgery (excluding total hip and knee replacements) - 90th Percentile Wait Time (Days)



	Actual	Target
10-Q4	286	182
11-Q1	281	182
11-Q2	240	182
11-Q3	235	182
11-Q4	237	182

Interpretation - Patient And Business:

This KPI for the final quarter displays a slight increase of 2 days although still a substantial improvement of 44 days from the first quarter. There were 341 cases completed in this quarter with 9 cases having accumulated wait times between 150 to 991 days. The median wait in March was 68 days which was a 2 day improvement from January and February. The additional operative time continues to positively influence the long patient wait lists.

Actions & Monitoring Underway to Improve Performance:

Wait times will continue to be monitored at the joint KGH/HDH Wait list committee meetings. With the additional ortho trauma operative time allocated on weekends to KGH it is anticipated that the wait times will continue to improve.

Definition: For orthopedic surgery (excluding total hip and knee replacements) procedures, the Ontario WTS measures the wait time from when a patient and surgeon decide to proceed with surgery, until the time when the actual surgical procedure is completed. This interval is typically referred to as from "decision to treat" to "treatment". For wait times that are reported for the specific time period, calculations include all cases where the surgery ("treatment") was completed during that time period. The wait times are calculated by subtracting the "decision to treat" date from the "treatment" date, resulting in a wait time that is measured in days. The wait is calculated for each patient who received treatment within the most current time period, for a particular service area and hospital. The 90th percentile wait time is defined as the point at which 9 out of 10 patients have completed surgery.

Target: Baseline 08/09: 183 days, Target 09/10: 182 days, Target 10/11: 182 days, Target 11/12: 182 days.

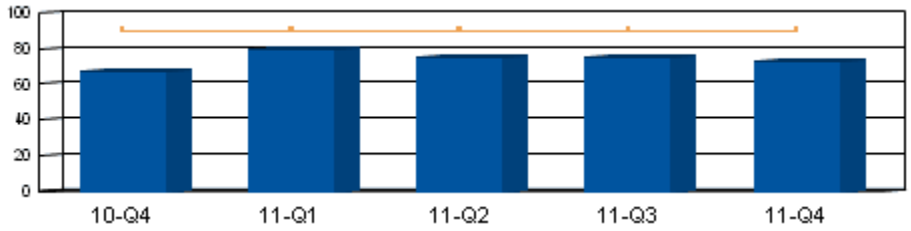
Kingston General Hospital

Milestone #8

SD1 Transform the patient experience through a relentless focus on quality, safety and service

90% of patients receive their elective surgery within or faster than the provincially targeted wait time

Indicator: Percent of Total Surgical Wait Times Meeting or Exceeding 90th Percentile Wait Time Targets



	Actual	Target
10-Q4	67	**90**
11-Q1	80	**90**
11-Q2	75	**90**
11-Q3	75	**90**
11-Q4	73	**90**

Interpretation - Patient And Business:

The Ontario government has put a plan in place to increase access and reduce wait times for most surgeries. Ontario's plan has a goal to significantly increase the number of procedures to reduce the backlog that has developed over the last decade, standardize best practices for both surgical and administrative functions in order to improve patient flow and efficiency and collect and report accurate and up-to-date data on wait times to allow better decision making and increase accountability.

Actions & Monitoring Underway to Improve Performance:

The Q4 results indicate that the target of 90% has still not been reached. Q4 results show that 32 of 44 (73%) of publically reported surgical wait times meet the 90th percentile wait time target. As of Q4, 4 procedure in General Surgery, 1 in Oral/maxillofacial surgery (peds), 3 in Orthopedic surgery, 2 in plastic surgery, and 2 in Urology. The surgical program leadership closely monitors wait times in conjunction with the Wait Times Committee. Departments and Divisions are informed of their rates and encouraged to look at means to improve wait times

Definition: The Ontario Wait Time Strategy (WTS) measures the wait time from when a patient and surgeon decide to proceed with surgery, until the time when the actual surgical procedure is completed. This interval is typically referred to as from ""decision to treat"" to ""treatment"". For wait times that are reported for the specific time period, calculations include all cases where the surgery or (""treatment"") was completed during that time period. The wait times are calculated by subtracting the ""decision to treat"" date from the ""treatment"" date, resulting in a wait time that is measured in days. The wait is calculated for each patient who received treatment within the most current time period, for a particular service area and hospital. The 90th percentile wait time is defined as the point at which 9 out of 10 patients have completed surgery.
The KGH is mandated to report 90th percentile wait times in 40 unique categories to the MoH on a monthly basis. This performance indicator simply counts the number of those unique categories meeting the 90th percentile target and dividing that by the total number of unique categories expressed as a percentage. It is intended to provide an overall view of progress with respect to meeting MoH wait time targets.

Target: Target 11/12: 90%

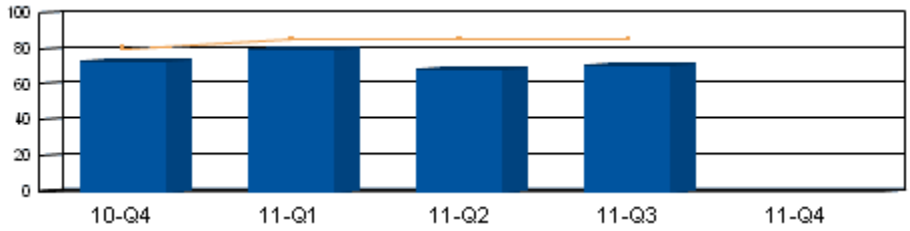
Kingston General Hospital

Milestone #8

SD1 Transform the patient experience through a relentless focus on quality, safety and service

90% of patients receive their elective surgery within or faster than the provincially targeted wait time

Indicator: Radiation Wait time (Referral-Consult) Percent seen within 14 days



	Actual	Target
10-Q4	73	**80**
11-Q1	80	**85**
11-Q2	68	**85**
11-Q3	71	**85**
11-Q4		

Interpretation - Patient And Business:

Q3 results show an overall wait time of 70.9% of new patients referred to KGH for a consultation with a radiation oncologist were seen within 14 days of referral. The 2011/12 target is 85%. Q4 results are not available until mid-May 2012

Actions & Monitoring Underway to Improve Performance:

Q4 data not yet available

Definition: Cancer Care Ontario (CCO) reports the proportion of patients who are being seen or receiving radiation treatment within the recommended timeframe or target. Referral to Consult: The time between a referral to radiation oncologist to the time that oncologist consults with the patient. This is based on the waiting period from the time a regional cancer centre receives a referral for a patient to have their initial consultation appointment with the oncologist. KGH's 2009/10 target is 75%. The provincial target/benchmark for radiation referral to consult is 80% of patients are seen within 14 days of receipt of the referral to the regional cancer centre. This region specific target is established on an annual basis with CCO before the end of Q4 of the previous year.

Target: Target 09/10: 80%, Target 10/11: 80%, Target 11/12: 80%.

Strategy milestone # 9

100% of our clinical areas have implemented ICPM

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Bring to life new models of interprofessional care and education	**Our Interprofessional Collaborative Practice Model (ICPM) is implemented in every clinical area with high ratings from patients, staff and learners**	**Roll out the KGH model of interprofessional collaborative practice in every clinical area**

Indicator(s)	Status
Implementation of ICPM in all inpatient units and extended to ambulatory settings by March 2012	**Green**

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   The goal of having the KGH model of interprofessional collaborative practice rolled out in every clinical area has been met with the KGH based clinics, Ventilator Equipment Pool, laboratories , Cancer Centre and Emergency being launched in Q4.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** The project infrastructure, with charter, steering committee and project manager, were critical success factors. For the most part, what started as a “push out” to clinical areas became more of a “pull in” by clinical care teams, and based upon both evaluation measure and incidental feedback, this can be attributed to what were perceived as positives with improved processes, improved communication and team work, and improved patient satisfaction and positive feedback.

3. **Are we on track to meet the milestone by year end?**
   All clinical areas have launched the ICPM. There is appreciation of need to refine processes, roles, etc and to stabilize the areas most recently launched.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Evaluation continues at 30 months post-implementation on 5 inpatient units and at 6 months post-implementation for 8 ambulatory areas. In the next year, the work related to ICPM will transition from project mode to part of operations with oversight by the office of Interprofessional Care and Education. Emphasis will be on support, sustainability and ongoing improvements including interprofessional documentation.

Kingston General Hospital

Milestone #9

				10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
SD2 Bring to life new models of interprofessional	100% of our clinical areas have implemented ICPM		Implementation of ICPM in All Inpatient Units and Extended to Ambulatory Setting by March 2012	N/A	G	G	G	G	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

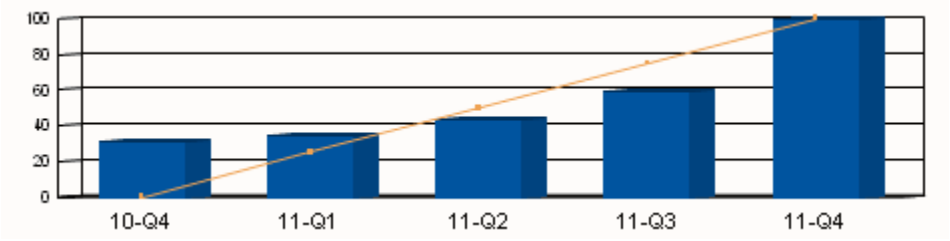
Kingston General Hospital

Milestone #9

SD2 Bring to life new models of interprofessional care and education

100% of our clinical areas have implemented ICPM

Indicator: Implementation of ICPM in All Inpatient Units and Extended to Ambulatory Setting by March 2012



	Actual	Target
10-Q4	31	**0**
11-Q1	35	**25**
11-Q2	44	**50**
11-Q3	59	**75**
11-Q4	100	**100**

Interpretation - Patient And Business:

The goal of having the ICPM rolled out in every clinical area has been met. By Q4, 51 of 51 (100%) patient care areas have implemented the ICPM.

In Q4, ICPM was implemented in 21 areas including KGH based clinics, Ventilator Equipment Pool, Laboratories, Cancer Centre and the Emergency Department.

The implementation support teams continue to refine roles and processes. The Education Team facilitated education sessions for 549 staff from the ambulatory care areas listed above during this quarter. To date, 2,053 staff, physicians, volunteers and learners have attended ICPM education sessions.

Actions & Monitoring Underway to Improve Performance:

The project infrastructure, with charter, steering committee and project manager, were critical success factors.

In the next year, the work related to ICPM will transition from project mode to part of operations with oversight by the office of Interprofessional Collaborative Care and Education. Emphasis will be on support, sustainability and ongoing improvements including interprofessional documentation.

Evaluation continues at 30 months post-implementation on 5 inpatient care units and at 6 months post-implementation for 8 ambulatory care areas.

KGH is sharing the ICPM information internally and externally. In Q4, ICPM was presented at the Nursing Research Council of Southeastern Ontario conference and teleconferences have occurred with representatives from St. Joseph's Hospital, Toronto, Alberta Health Services, Health PEI, and Providence Continuing Care Centre.

Definition: Percent completion of ICPM implementation in 51 patient care areas. ICPM implementation is defined as putting into action all role, process improvement, documentation, technology and staffing changes following stakeholder engagement and completion of staff and physician education. The evaluation strategy is approved and in progress.

Target: Target 11/12: 100%

Strategy milestone # 10

The KGH Interprofessional Education Steering Committee and workplan is in place

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Bring to life new models of interprofessional care and education	KGH is recognized as a centre of excellence in interprofessional education	Establish an Interprofessional Education Steering Committee

Indicator(s)	Status
IPE Work Plan Launched	Green

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   The IPE workplan, as approved by the Operations Committee, has guided the activities of the IPE Steering Committee, and the 5 support teams (Accreditation Alignment, Environmental Factors, Interprofessional Events Planning, Evaluation and Communication).

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The project infrastructure with charter, steering committee, work teams and project manager has been critical. The presence, engagement and support of academic partners, Queen's University and St. Lawrence College, have contributed to the nature and credibility of the discussion and work. There is recognition that this is the first year of work on IPE, and of the need for greater profile within the organization to promote awareness and garner interest and further engagement.

3. **Are we on track to meet the milestone by year end?**
   The 2012 milestone has been met.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   In addition to overseeing implementation of a 2013 IPE action plan, the project team will focus on ensuring that KGH demonstrates the accountabilities expected of an organization that supports professional/interprofessional education.

Kingston General Hospital

Milestone #10

				10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
SD2 Bring to life new models of interprofessional	The KGH Interprofessional education council		IPE Work Plan Launched	G	G	G	G	G	

Indicates improving performance to target over the past 5 quarters 

Indicates worsening performance to target over the past 5 quarters 

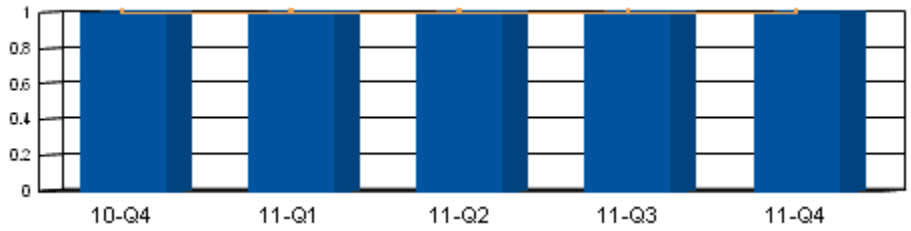
Kingston General Hospital

Milestone #10

SD2 Bring to life new models of interprofessional care and education

The KGH Interprofessional education council and work plan is in place

Indicator: IPE Work Plan Launched



	Actual	Target
10-Q4	1	**1**
11-Q1	1	**1**
11-Q2	1	**1**
11-Q3	1	**1**
11-Q4	1	**1**

Interpretation - Patient And Business:

The 2012 milestone has been met.

The IPE workplan, as approved by the Operations Committee, has guided the activities of the IPE Steering Committee, and the 5 support teams (Accreditation Alignment, Environmental Factors, Events Planning, Evaluation, and Communication).

A strategic planning session took place in 2012 March to refresh the workplan for the next 18 months. Nine action items were identified and measures suggested for each.

In addition to overseeing implementation of a 2013 IPE action plan, the project team will focus on ensuring that KGH demonstrates the accountabilities expected of an organization that supports professional/interprofessional education.

Actions & Monitoring Underway to Improve Performance:

The project infrastructure with charter, steering committee, work teams and project manager has been critical. The presence, engagement and support of academic partners, Queen's University and St. Lawrence College, have contributed to the nature and credibility of the discussion and work. There is recognition that this is the first year of work on IPE, and of the need for greater profile within the organization to promote awareness and garner interest and further engagement.

The Interprofessional Education Steering Committee reports to the Operations Committee and provides monthly updates.

The executive sponsor presented an update to the Research and Education Committee in 2012 February.

Definition: The IPE project charter forms the basis of the IPE work plan. The work plan includes establishment of working groups with defined terms of reference, objectives and deliverables, initiative timelines, project milestones, and the IPE communication and evaluation strategies.

Target: Target 11/12: Yes

Strategy milestone # 11

Externally funded research at KGH has increased by 10% and our clinician scientist program expands

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Cultivate patient oriented research	Externally funded research at KGH has increased by 50%	Expand the number of clinician scientists conducting research at KGH

Indicator(s)	Status
Expand Number of Clinician Scientists	Green
Percent Increase of Externally Funded Research Dollars at KGH	Green
Research Institute Business and Operating Plan Delivered	Green

1. What is our actual performance on each of the indicators for this milestone as listed above?

Our efforts to build upon a culture of patient-oriented research at KGH continue to expand through the creation of the KGH Research Institute (KGHRI), the recruitment of four clinician scientists to date (*Emergency Medicine, Pathology & Molecular Medicine, Respirology, and Neurosurgery*), and through ongoing planning for clinical research space, increasing research personnel, and creating a strategic plan for research at KGH. As of Q4, all three indicators have reached a status of green. A Needs Assessment for the KGHRI has been completed and disseminated to EMC. It includes a draft floor plan for a new Clinical Investigation Unit and a marketing/communication strategy for the KGHRI. A draft research strategic plan has been created and will be disseminated to EMC by the end of Q1 of F13.

2. What are the contributing factors to the current performance of the indicators for this milestone?

Our success has been fostered through KGH's commitment and the cooperation of SEAMO and the Queen's University Faculty of Health Sciences on our common quest to establish leadership in the Canadian health research domain.

3. Are we on track to meet the milestone by year end?

Yes. We have already exceeded our target of one new clinician scientist recruited and externally-funded research has increased 32% by fiscal year end (38% relative to baseline). The research institute business and operating plan were delivered through the needs assessment.

4.What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?

There is no requirement for corrective actions at this time as our milestones for this year have been met by year end.

Kingston General Hospital

Milestone #11

			10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
SD3 Cultivate patient oriented research	Externally funded research at KGH has increased by 10% and our clinician scientist program expands	Active Clinical Trials	G	G	G	G	G	↑
		Clinical Trials Generating Revenue	G	G	G	G	G	↑
		Expand Number of Clinician Scientists	N/A	G	G	G	G	↑
		New Clinical Trials	G	G	R	R	G	↑
		Percent Increase of Externally Funded Research Dollars at KGH	N/A	N/A	G	G	G	↑
		Research Institute Business and Operating Plan Delivered		N/A	N/A	N/A	G	

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

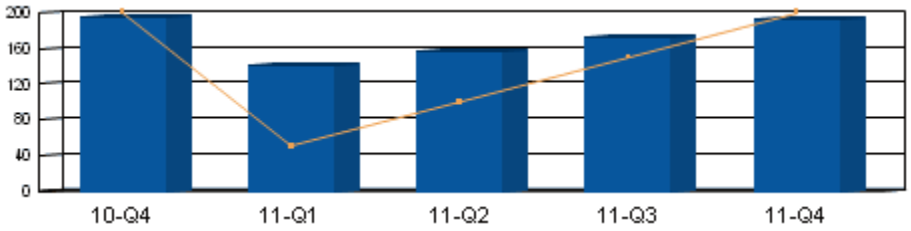
Kingston General Hospital

Milestone #11

SD3 Cultivate patient oriented research

Externally funded research at KGH has increased by 10% and our clinician scientist program expands

Indicator: Active Clinical Trials



	Actual	Target
10-Q4	196	**200**
11-Q1	140	**50**
11-Q2	157	**100**
11-Q3	172	**150**
11-Q4	192	**200**

Interpretation - Patient And Business:

Patient Perspective: Based on the fiscal year to date, patients had access to clinical trials at KGH during Q4.

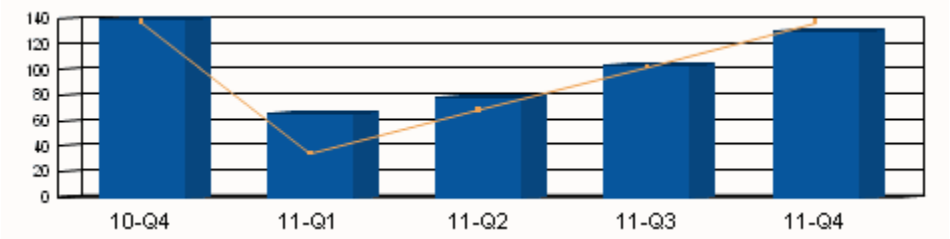
Business Perspective: Based on the fiscal year to date, KGH reached its targets by the end of the fourth quarter (Q4).

Definition: The Council of Academic Hospitals of Ontario (CAHO) is moving to adopt research as the defining characteristic of an academic hospital. Research attracts the most highly qualified staff, it helps to build public and patient confidence, it drives evidence based care, and it provides local access to clinical trials, new treatment modalities and technologies. In order to be considered an academic hospital under the CAHO definition, total research funding attributable to the hospital must exceed $10M. In depth reporting on research activity and funding at KGH is provided annually in the 'Annual Research Report' in the Fall of the subsequent fiscal year. However, various indicators related to clinical trials activity can and will be provided on a quarterly basis.

The majority of clinical trials within KGH are funded through external granting agencies (i.e. CIHR) or industry/corporation sponsors.

Target: Baseline 08/09: 195 Trials, Target 09/10: 200 Trials (2.5% increase), Target 10/11: 200 Trials. Target 11/12: 200 Trials.

Indicator: Clinical Trials Generating Revenue



	Actual	Target
10-Q4	139	**137**
11-Q1	66	**34**
11-Q2	79	**68**
11-Q3	103	**102**
11-Q4	131	**137**

Interpretation - Patient And Business:

Patient Perspective: Based on the fiscal year to date, patients had access to clinical trials at KGH during Q4.

Business Perspective: Based on the fiscal year to date, KGH reached its targets by the end of the fourth quarter (Q4).

Definition: The Council of Academic Hospitals of Ontario (CAHO) is moving to adopt research as the defining characteristic of an academic hospital. Research attracts the most highly qualified staff, it helps to build public and patient confidence, it drives evidence based care, and it provides local access to clinical trials, new treatment modalities and technologies. In order to be considered an academic hospital under the CAHO definition total research funding attributable to the hospital must exceed $10M. In depth reporting on research activity and funding at KGH is provided annually in the 'Annual Research Report' in the Fall of the subsequent fiscal year. However, various indicators related to clinical trials activity can and will be provided on a quarterly basis.

The majority of clinical trials within KGH are funded through external granting agencies (i.e. CIHR) or industry/corporation sponsors.

Target: Baseline 08/09: 125 Trials, Target 09/10: 137 Trials (10% increase), Target 10/11: 137 Trials. Target 11/12: 137 Trials.

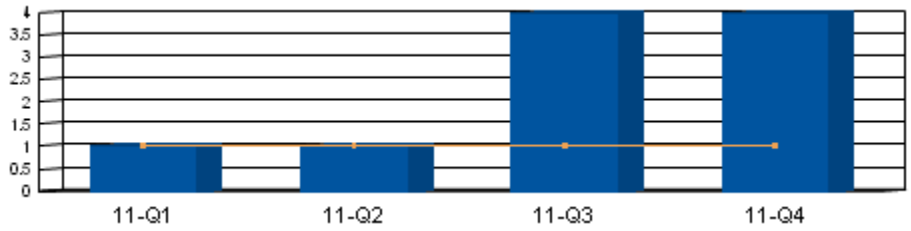
Kingston General Hospital

Milestone #11

SD3 Cultivate patient oriented research

Externally funded research at KGH has increased by 10% and our clinician scientist program expands

Indicator: Expand Number of Clinician Scientists



	Actual	Target
11-Q1	1	1
11-Q2	1	1
11-Q3	4	1
11-Q4	4	1

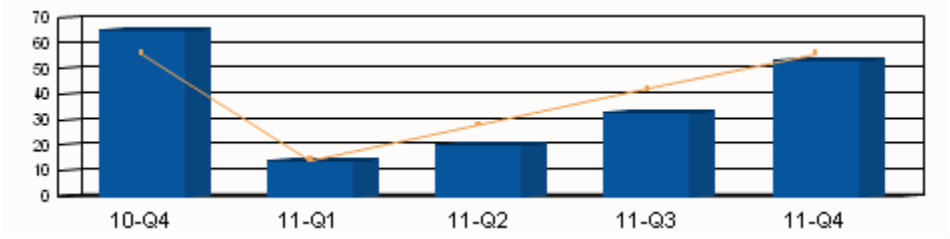
Interpretation - Patient And Business:

First and second competitions of the SEAMO Clinician Scientists Recruitment Program were held in spring and fall 2011. Four (4) clinician scientists will be coming to KGH (Emergency Medicine, Pathology, Respirology, and Neurosurgery).

Definition: Commencing in the 2011-12 fiscal year, $3.6 million dollars will be capitalized annually to fund 2 to 3 new clinician scientist positions of 5 years duration within the Queen's Faculty of Health Sciences, creating over a 5 year period 10-15 new clinician scientist positions. Some of these clinician scientists will reside in KGH. The new SEAMO Clinician Scientists Recruitment Program supports SEAMO's objective of significantly expanding its clinical research enterprise by increasing SEAMO's clinical scientist research capacity. A clinician scientist is defined as a physician who leads, or is deemed to have the potential to lead, a research program that is supported by sustained funding from external agencies.

Target: Target = 1 or greater in 11/12

Indicator: New Clinical Trials



	Actual	Target
10-Q4	65	56
11-Q1	14	14
11-Q2	20	28
11-Q3	33	42
11-Q4	53	56

Interpretation - Patient And Business:

Patient Perspective: Based on the fiscal year to date, patients had access to new clinical trials at KGH during Q4.

Business Perspective: Based on the fiscal year to date, KGH reached its target by the end of the fourth quarter (Q4). As per our Affiliation Agreement with Queen's University, clinical trial contracts, agreements and grants are administered by the Office of Research Services' Contracts Office.

Definition: The Council of Academic Hospitals of Ontario (CAHO) is moving to adopt research as the defining characteristic of an academic hospital. Research attracts the most highly qualified staff, it helps to build public and patient confidence, it drives evidence based care, and it provides local access to clinical trials, new treatment modalities and technologies. In order to be considered an academic hospital under the CAHO definition total research funding attributable to the hospital must exceed $10M. In depth reporting on research activity and funding at KGH is provided annually in the 'Annual Research Report' in the Fall of the subsequent fiscal year. However, various indicators related to clinical trials activity can and will be provided on a quarterly basis.

The majority of clinical trials within KGH are funded through external granting agencies (i.e. CIHR) or industry/corporation sponsors.

Target: Baseline 08/09: 53 Trials, Target 09/10: 56 Trials (5% increase), Target 10/11: 56 Trials. Target 11/12: 56 Trials.

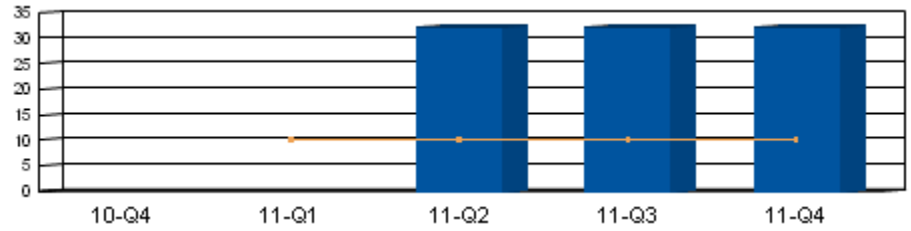
Kingston General Hospital

Milestone #11

SD3 Cultivate patient oriented research

Externally funded research at KGH has increased by 10% and our clinician scientist program expands

Indicator: Percent Increase of Externally Funded Research Dollars at KGH



	Actual	Target
10-Q4		
11-Q1		10
11-Q2	32	10
11-Q3	32	10
11-Q4	32	10

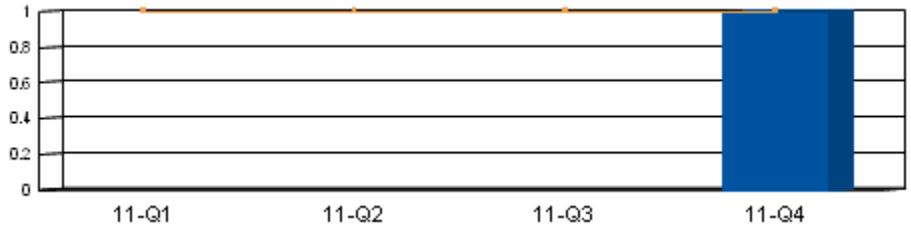
Interpretation - Patient And Business:

Real F2011 data will be used for reporting of F2012 data for this performance indicator since real figures for F2012 will not be available until September 2012. 95% of the data is obtained from external sources and is not available on a quarterly basis for reporting.

Definition: The KGH 2015 Strategy Plan calls for externally-funded research at KGH to increase by 50% by the end of F2015. Researchers at KGH received $15.6 and $16.3 million dollars in external funding from government sources, foundations, societies and agencies, industry, and other sources in F2009 and F2010 respectively.

Target: Target 11/12: 10% increase from 08/09

Indicator: Research Institute Business and Operating Plan Delivered



	Actual	Target
11-Q1		1
11-Q2		1
11-Q3		1
11-Q4	1	1

Interpretation - Patient And Business:

Needs assessment completed. Draft floor plan for clinical investigation unit on Connell 4 created. Draft research strategic plan completed. Research priorities and themes identified.

Definition: Kingston General Hospital (KGH) Research Institute (KGHRI) is the research arm of KGH, a teaching hospital fully affiliated with Queen's University. We have already moved forward in a deliberate way with the establishment of the KGHRI entity in F2011, which will provide a platform to help create an environment where patient-oriented research will flourish. The next steps involve the creation of the KGHRI business and operating plans in F2012 for the next 5-10 years.

Target: plans completed by Q4 in 11/12

Strategy milestone # 12

KGH services align with our role as the region's complex-acute and specialty care provider and the Cancer Care at KGH strategic plan is in place

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Increase our focus on complex-acute and specialty care	KGH services are well aligned and integrated with the broader health care system	Participate in the South East LHIN's Clinical Services Roadmap project and create a Cancer Care at KGH strategy

Indicator(s)	Status
KGH Cancer Care Plan in Place	Green
KGH Participation in Clinical Services Roadmap Initiatives	Green

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   The Oncology program developed a strategic plan aligned to the KGH 2015 strategy. Cancer Care @ KGH strategy was presented to and approved by KGH Executive Management Committee on March 29, 2012. The strategy was delivered on time, achieving the 2011/12 Work plan milestone. KGH continues to participate in the SE LHIN Clinical Services Roadmap (CSR) initiative. The process in currently assessing implementation of some initiatives.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The entire Oncology Program was engaged in the development of the KGH Cancer Care Plan with the Regional RVP (B.C) as lead. KGH actively participates at SECHEF and the clinical services roadmap working with regional partners on prioritization and implementation of initiatives.

3. **Are we on track to meet the milestone by year end?**
   Yes. This milestone was met.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   With the completion of the Cancer Care @ KGH strategy, implementation planning will start in April to develop the detailed plans required to begin the roll out of Year 1 of the strategy.

Kingston General Hospital

Milestone #12

				11-Q1	11-Q2	11-Q3	11-Q4	
SD4 Increase our focus on complex-acute and specialty care	KGH services align with our role as the region's complex-acute and specialty care provider and the Cancer Care at KGH strategic plan		KGH Cancer Care Plan	G	G	G	G	↑
			KGH Participation in Clinical Services Roadmap Initiatives	G	G	G	G	↑

Indicates improving performance to target over the past 5 quarters ↑

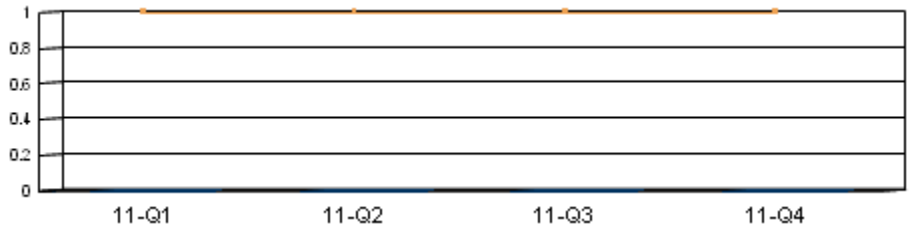
Indicates worsening performance to target over the past 5 quarters ↓

Milestone #12

SD4 Increase our focus on complex-acute and specialty care

KGH services align with our role as the region's complex-acute and specialty care provider and the Cancer Care at KGH strategic plan is in place

Indicator: KGH Cancer Care Plan



	Actual	Target
11-Q1	0	1
11-Q2	0	1
11-Q3	0	1
11-Q4	0	1

Interpretation - Patient And Business:

The Cancer Care @ KGH strategy was presented to and approved by KGH Executive Management Committee on March 29, 2012. The strategy was delivered on time, achieving the 2011/12 Workplan milestone.

Actions & Monitoring Underway to Improve Performance:

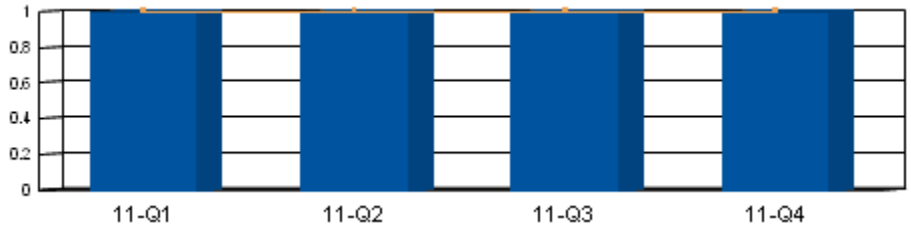
With the completion of the Cancer Care @ KGH strategy, implementation planning will start in April to develop the detailed plans required to begin the roll out of Year 1 of the strategy.

This strategy, along with detailed workplans provides clarity on the key goals and objectives for cancer care program and service development as they align to KGH's 2015 strategy, Ontario Cancer Plan III and the South East Regional Cancer Program plan.

Definition: A plan for Cancer Care at KGH will be in place by the end of March 2012 as articulated in the KGH 2015 Action plan for achieving Outstanding Care, Always. The cancer care plan will consider the strategic directions in the KGH 2015 strategy as well as the priorities articulated in Cancer Care Ontario's Ontario Cancer Plan III and the South East Regional Cancer Program plan. As a guide to the strategic development, choices and investments in cancer care, research and education to 2015, this plan will be instrumental in achieving Outstanding Cancer Care, Always at KGH. The process used to develop the cancer care plan will serve as an example of clinical planning that can be used by others within KGH to map their efforts to the 2015 strategy and action plan.

Target: Target 11/12: Yes

Indicator: KGH Participation in Clinical Services Roadmap Initiatives



	Actual	Target
11-Q1	1	1
11-Q2	1	1
11-Q3	1	1
11-Q4	1	1

Interpretation - Patient And Business:

The SE LHIN and the regional hospitals with CCAC have embarked upon a critical examination of current hospital services within seven clinical areas. The goal is to improve service provision, reduce program duplication and improve access, efficiency and effectiveness. Working groups with representation from all partners have focused on the clinical area of cardiovascular disease, emergency department wait times, healthcare acquired infections, maternal/high risk newborn, mental health and addictions services, restorative care and surgery.

Actions & Monitoring Underway to Improve Performance:

KGH's clinical programs and leadership continue to actively participate in the development of the roadmap. The prioritization team has identified initiatives that are currently already underway or implementable with current resources. These will commence as the first wave as agreed at SECHEF. Implementation planning will begin on a number of others.

Definition: KGH's ability to fulfill its role as the academic tertiary care center to the region in part requires an integrated, strategic approach to health care in the SE LHIN. Regional partners working to their scope, rely on KGH to provide the complex-acute and specialty level care. KGH's participation and leadership within the clinical services roadmap will help meet this objective. The similar alignment of the Cancer Care strategic plan will similarly meet the same objective for this complex group of patients.

Target: Target 11/12: Yes

Strategy milestone # 13

100% of target service volumes are met

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Increase our focus on complex-acute and specialty care	**KGH services are well aligned and integrated with the broader health care system**	**Deliver on MOH volume contracts**

Indicator(s)	Status
Percent of Wait Time Contracted Volumes Achieved	**Yellow**

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   As of Q4, there were 3 of 10 incremental volume contracts that were not on target (ventral hernia, total joint replacements, and MRI hrs)

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   During Q4, incremental volumes for both hernia repair and total joint replacements were returned to the SE LHIN for redistribution. As a result, there is no financial penalty to the hospital. In the case of MRI hrs, despite the Q4 target being achieved the yearend target was missed just 66 hrs or 1.4%. This was due to staffing shortfalls in the early part of the year that have since been rectified.

3. **Are we on track to meet the milestone by year end?**
   The milestone was not met at end of Q4 and year end.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**

   The SPA program and Wait Times Committee meets with the programs managing services volumes and closely monitors the volume metrics.

Kingston General Hospital

Milestone #13

				10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
SD4 Increase our focus on complex-acute and specialty care	100% of Target service volumes are met		Stem Cell Transplants	G	G	G	G	G	↑
			Ambulatory Care Volumes	G	G	G	G	G	↑
			Cardiac - Angiography Volumes	G	G	G	G	G	↑
			Cardiac - Angioplasty Volumes	G	G	G	G	G	↑
			Cardiac - Bypass Volumes	G	G	G	G	G	↑
			Chronic Kidney Disease Program- Weighted Units	G	G	G	Y	G	↑
			CT Hours (Wait Time Strategy Allocation)	G	G	G	G	G	↑
			Emergency Department Admitted Patient Volumes – All Levels of Acuity	G	G	G	G	G	↑
			Emergency Department Non-Admitted Low Acuity (CTAS 4&5) volumes	G	G	G	G	G	↑
			Emergency Department Non-Admitted Patient Visits – High Acuity	G	G	G	G	G	↑
			Hip and Knee Replacement Volume (Wait Time Strategy Allocation)	G	Y	Y	G	Y	↓
			Kidney Transplants	Y	G	R	R	G	↑
			MRI Hours (Wait Time Strategy Allocation)	R	G	Y	G	G	↑
			OR Cases (Inpatient and Outpatient))	G	G	G	G	G	↑

			10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
SD4 Increase our focus on complex-acute and specialty care	100% of Target service volumes are met	OR Hours (Inpatient & Outpatient)	Y	G	G	G	G	↑
		Percent of Wait Time Contracted Volumes Achieved	N/A	R	Y	Y	Y	↓
		Total Inpatient Admissions	G	G	G	G	G	↑
		Total Inpatient Weighted Cases	G	G	G	G	N/A	↑

Indicates improving performance to target over the past 5 quarters ↑

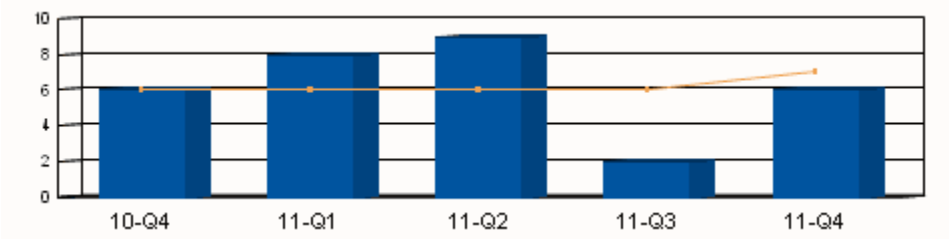
Indicates worsening performance to target over the past 5 quarters ↓

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: Stem Cell Transplants



	Actual	Target
10-Q4	6	6
11-Q1	8	6
11-Q2	9	6
11-Q3	2	6
11-Q4	6	7

Interpretation - Patient And Business:

GH has established its 2011/12 annual stem cell transplant volume at 25 (13 cases included in the Hospital's base budget and 12 incremental cases funded by Cancer Care Ontario).

In Q4 2011/12, 6 stem cell transplants were completed, bringing the YTD total to 25 which is on target for annual allocations.

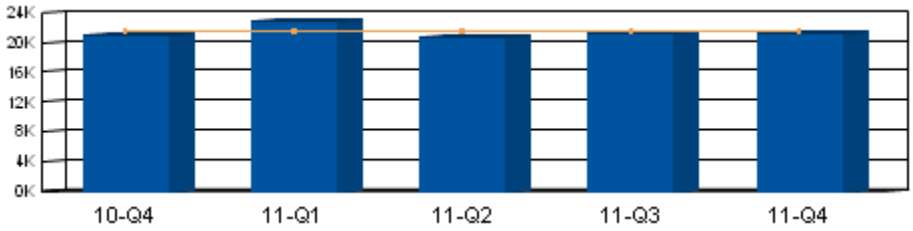
Actions & Monitoring Underway to Improve Performance:

In line with KGH's strategic direction for complex and specialty care, KGH is the only provider of autologous stem cell transplants in the SE region. Timely access to this important cancer treatment modality to patients referred to KGH continues to be provided. KGH maximizes incremental funding available from Cancer Care Ontario to offer this treatment closer to home.

Definition: Number of Stem Cell Transplants (SCT) is a volume funded program that is currently being monitored by the Ministry of Health and Long Term Care/LHIN and Cancer Care Ontario. Stem Cell Transplants (autologous) require the harvesting of the patient's own stems cells prior to the delivery of high doses of chemotherapy that is intended to target and kill cancer cells present in the blood. Once the chemotherapy has been administered, the patient's own stem cells (previously harvested) are reintroduced into the patient to allow for the generation of new healthy, cancer free stem cells. This is a highly intensive treatment requiring extended hospital stays and specific expertise. Autologous SCTs are known to be effective for patients with myeloma, non-Hodgkin's Lymphoma, Hodgkin's disease and on the rare occasion testicular cancer. The hospital is funded based on the total workload achieved by the program within contracted volumes outlined in the Hospital Services Accountability Agreement (HSAA).

Target: Baseline 08/09: 8, Target 09/10: 44, Target 10/11: 44, Target 11/12: 25

Indicator: Ambulatory Care Volumes



	Actual	Target
10-Q4	21050	21400
11-Q1	22878	21400
11-Q2	20797	21400
11-Q3	21184	21400
11-Q4	21194	21400

Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: Total number of ambulatory care visits to the hospital

Target: Baseline 08/09: 85594, Target 09/10: 85594, Target 10/11: 85594, Target 11/12: 85292

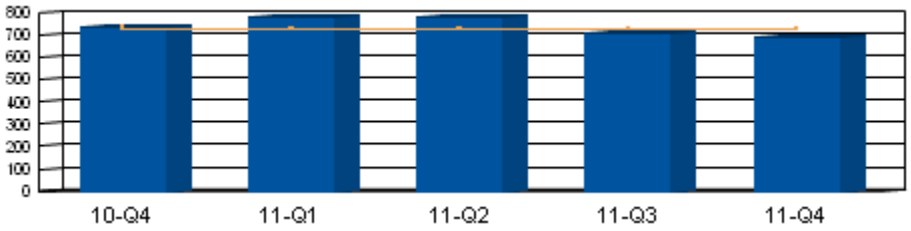
Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: Cardiac - Angiography Volumes



	Actual	Target
10-Q4	731	**729**
11-Q1	779	**725**
11-Q2	777	**725**
11-Q3	705	**725**
11-Q4	686	**725**

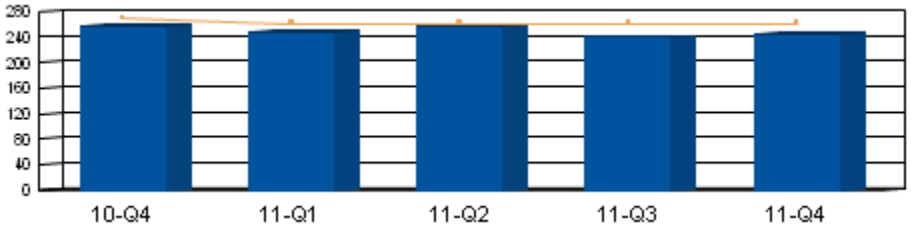
Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: In order to strategically increase service in select clinical services the Province has provided funds to support expanded volumes in some key areas. Angiography procedures are one of the select areas. For the past few years the Province has offered funding to some hospitals on an annual basis to expand capacity of service. As hospitals already have funding for a base level of services, the additional incremental funding must be earned by expanding services beyond the Base Volumes. Given that KGH has been selected to provide additional volumes, our definition of this performance indicator is Base volumes plus WTS Incremental cases plus any additional in-year SE LHIN volume adjustments. Coronary angiography means taking pictures of blood vessels in the heart. Angiography involves injecting a dye that is visible to x-rays. The physician uses an x-ray machine to guide him or her through the procedure and record the pictures to determine whether or not there is adequate blood flow through the vessels.

Target: Baseline 08/09: 1709, Target 09/10: 3100, Target 10/11: 3100, Target 11/12: 2900

Indicator: Cardiac - Angioplasty Volumes



	Actual	Target
10-Q4	257	**270**
11-Q1	249	**262**
11-Q2	256	**262**
11-Q3	240	**262**
11-Q4	245	**262**

Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: In order to strategically increase service in select clinical services the Province has provided funds to support expanded volumes in some key areas. Angioplasty procedures are one of the select areas. For the past few years the Province has offered funding to some hospitals on an annual basis to expand capacity of service. As hospitals already have funding for a base level of services, the additional incremental funding must be earned by expanding services beyond the Base Volumes. Given that KGH has been selected to provide additional volumes, our definition of this performance indicator is Base volumes plus WTS Incremental cases plus any additional in-year LHIN volume adjustments. Coronary angioplasty is a procedure which unblocks narrowed arteries by inserting a small balloon into each artery and inflating the balloon at the site of the blockage. Often, a small metal tube (stent) is permanently placed in the artery to help keep the artery open. This allows blood to flow freely through the artery.

Target: Baseline 08/09: 1084, Target 09/10: 1150 , Target 10/11: 1150, Target 11/12: 1050

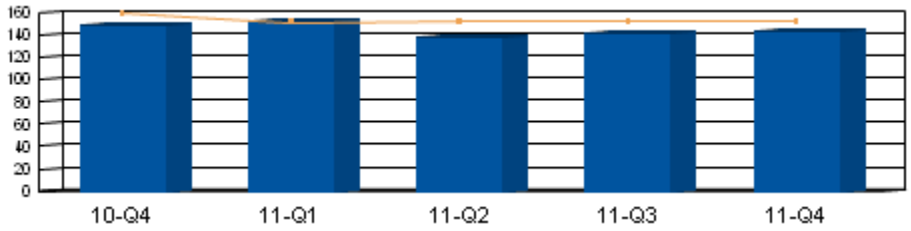
Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: Cardiac - Bypass Volumes



	Actual	Target
10-Q4	148	159
11-Q1	153	151
11-Q2	138	152
11-Q3	141	152
11-Q4	143	152

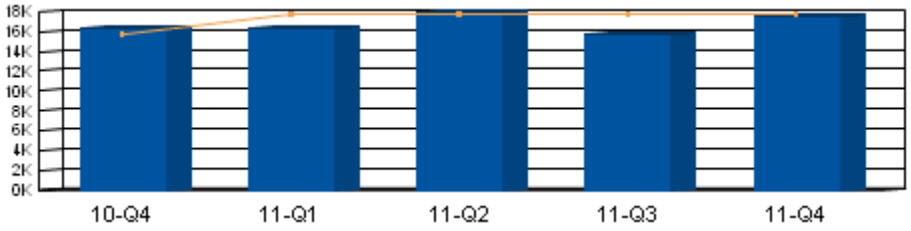
Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: Wait Time Strategy (WTS) Allocation: In order to strategically increase service in select clinical services, the Province has provided funds to support expanded volumes in some key areas - cardiac bypass procedures are one of the selected areas. For the past few years the province has offered funding to some hospitals on an annual basis to expand capacity of service. As hospitals already have funding for a base level of services, the additional incremental funding must be earned by expanding services beyond the base volumes. Given that KGH has been selected to provide additional volumes, our definition of this performance indicator is base volumes plus WTS incremental cases plus any additional in-year LHIN volume adjustments.

Target: Target 10/11: 580, Target 11/12: 606

Indicator: Chronic Kidney Disease Program- Weighted Units



	Actual	Target
10-Q4	16290	15655
11-Q1	16265	17707
11-Q2	17888	17707
11-Q3	15792	17707
11-Q4	17638	17707

Interpretation - Patient And Business:

Overall units of service (weighted units) has remained relatively stable across the year. Units include all aspects of service provided for patients across the chronic kidney disease continuum of care which spans many years at a patient perspective.

Actions & Monitoring Underway to Improve Performance:

Renal disease is one of the first 4 services to see funding model changes in the next fiscal year (F2013), preparation is well underway and KGH is well positioned as the regional provider of this service/care dimension to implement the new funding model. Funding flexes with activity volumes (both up and down).

Definition: Chronic Kidney Disease (CKD) services is a volume funded service that is currently being monitored by Ontario Renal Network (an subdivision of Cancer Care Ontario) on behalf of the Ministry of Health and Long Term Care. The hospital is funded based on the total workload achieved by the service within contracted volumes outlined in the Hospital Services Accountability Agreement (HSAA). Activities specified by the HSAA are multiplied by MoH weighted units and then used for funding. Examples of weights: pre dialysis clinic visit = 1.21; level 1 dialysis treatment = 0.68; level 2 dialysis treatment = 1.00. The renal service (within the Medicine Program) delivers care across over 30 measured service points that together comprise the continuum of care for patients with Chronic Kidney Disease. The most familiar care element is that of dialysis.

Target: Baseline 08/09: 65240, Target 09/10: 69992, Target 10/11: 69992, Target 11/12: 70828

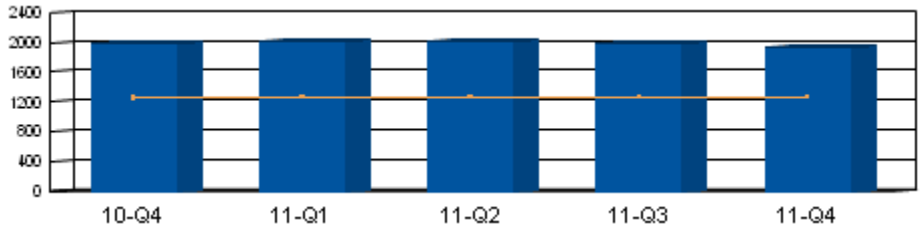
Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: CT Hours (Wait Time Strategy Allocation)



	Actual	Target
10-Q4	1987	**1247**
11-Q1	2012	**1263**
11-Q2	2015	**1263**
11-Q3	1979	**1263**
11-Q4	1929	**1263**

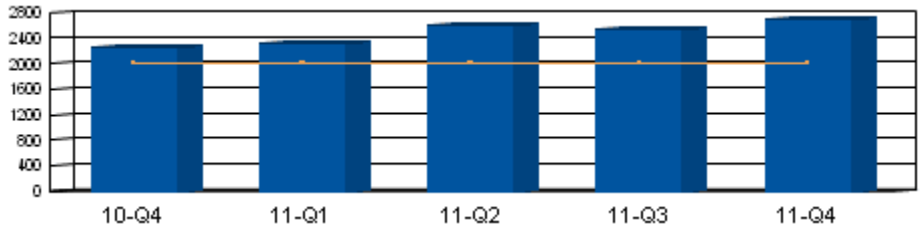
Interpretation - Patient And Business:

KGH continues to surpass targeted hours. The number of hours operated are required to meet the needs of the hospital, the ER department, the specialty exams and the Cancer Center patient population. To target less hours would have an immediate negative effect on the patient population as diagnosis and treatment would be delayed.

Definition: Wait Time Strategy (WTS) Allocation: In order to strategically increase service in select clinical services the Province has provided funds to support expanded volumes in some key areas. CT Hours is one of the select areas. For the past few years the Province has offered funding to some hospitals on an annual basis to expand capacity of service. As hospitals already have funding for a base level of services, the additional incremental funding must be earned by expanding services beyond the base volumes. Given that KGH has been selected to provide additional volumes, our definition of this performance indicator is base volumes plus WTS Incremental cases plus any additional in-year SE LHIN volume adjustments.

Target: Baseline 08/09: 8039 hrs, Target 09/10: 4888 hrs, Target 10/11: 4888 hrs, Target 11/12: 5050 hrs.

Indicator: Emergency Department Admitted Patient Volumes – All Levels of Acuity



	Actual	Target
10-Q4	2260	**2002**
11-Q1	2309	**2002**
11-Q2	2591	**2002**
11-Q3	2555	**2002**
11-Q4	2713	**2002**

Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: This is the number of patients in the Emergency Department (ED) (all levels of CTAS acuity) who are admitted and waiting for inpatient bed. (Note: CTAS – the Canadian Triage Acuity Scale and is a 5 level scale – level1 being the most acute and level 5 the least acute).

Target: Baseline 08/09: 8163, Target 09/10: 8163, Target 10/11: 8163, Target 11/12: 8008

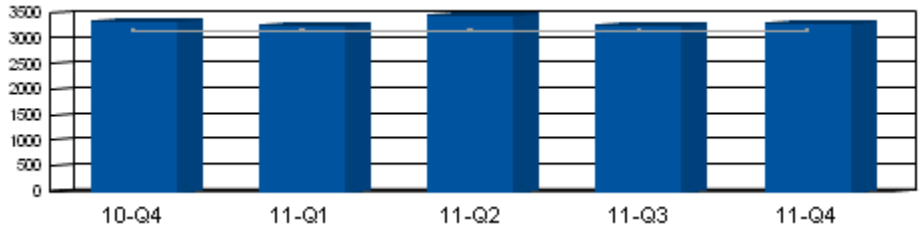
Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: Emergency Department Non-Admitted Low Acuity (CTAS 4&5) volumes



	Actual	Target
10-Q4	3322	**3138**
11-Q1	3257	**3138**
11-Q2	3441	**3138**
11-Q3	3250	**3138**
11-Q4	3284	**3138**

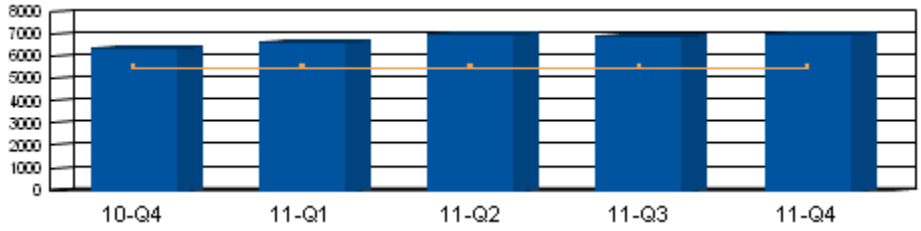
Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: This is the number of Emergency Department (ED) patient visits, low acuity (CTAS 4 & 5) that are seen in the ED and discharged from the ED.
(Note: CTAS – the Canadian Triage Acuity Scale and is a 5 level scale – level1 being the most acute and level 5 the least acute).

Target: Baseline 08/09: 14270, Target 09/10: 14270, Target 10/11: 14270, Target 11/12: 12552

Indicator: Emergency Department Non-Admitted Patient Visits – High Acuity



	Actual	Target
10-Q4	6380	**5481**
11-Q1	6599	**5481**
11-Q2	6953	**5481**
11-Q3	6867	**5481**
11-Q4	7033	**5481**

Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: This is the number of Emergency Department (ED) patient visits (high acuity) CTAS (Canadian Triage & Acuity Scale 1, 2 or 3) that are seen in the ED and discharged from the ED.
(Note: CTAS – the Canadian Triage Acuity Scale and is a 5 level scale – level1 being the most acute and level 5 the least acute).

Target: Baseline 08/09: 22823, Target 09/10: 22823, Target 10/11: 22823, Target 11/12: 21924

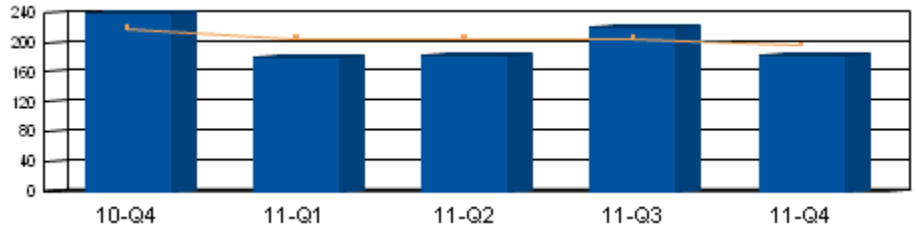
Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: Hip and Knee Replacement Volume (Wait Time Strategy Allocation)



	Actual	Target
10-Q4	239	219
11-Q1	180	205
11-Q2	183	205
11-Q3	221	205
11-Q4	183	196

Interpretation - Patient And Business:

During this final quarter, after a leadership review of the combined volumes for the previous three quarters, it was recognized that total case volumes could not be met, At this point the target for this indicator was reviewed and 35 incremental cases were returned and redistributed within the SELHIN region. The final target met for this year was 767 cases out of the baseline volume of 784 cases. Challenges existed within each quarter pertaining to environmental circumstances (humidity, code browns, etc) along with human resource limitations that made the ability to catch up on volumes in the preceding quarters unachievable.

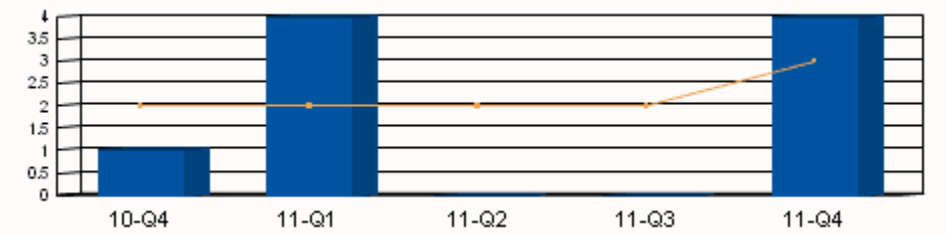
Actions & Monitoring Underway to Improve Performance:

New Quality Base Funding program will new volumes be introduced once details are announced.

Definition: Wait Time Strategy (WTS) Allocation: In order to strategically increase service in select clinical services the Province has provided funds to support expanded volumes in some key areas. Hip and Knee replacements are one of the select areas. For the past few years the Province has offered funding to some hospitals on an annual basis to expand capacity of service. As hospitals already have funding for a base level of services, the additional incremental funding must be earned by expanding services beyond the Base Volumes. Given that KGH has been selected to provide additional volumes, our definition of this performance indicator is Base volumes plus WTS Incremental cases plus any additional in-year LHIN volume adjustments.
The hospital is funded based on the total workload achieved by the program within contracted volumes outlined in the Hospital Services Accountability Agreement (HSAA).

Target: Baseline 08/09: 878, Target 09/10: 876, Target 10/11: 876, Target 11/12: 819

Indicator: Kidney Transplants



	Actual	Target
10-Q4	1	2
11-Q1	4	2
11-Q2	0	2
11-Q3	0	2
11-Q4	4	3

Interpretation - Patient And Business:

Kidney transplants based primarily on availability of organs. KGH current only provides cadaveric transplantation. The overall transplantation numbers this fiscal year is good, in that we have seen an increased number of available organs for transplantation.

Actions & Monitoring Underway to Improve Performance:

The unpredictable nature of available organs provides challenges of capacity and staff preparedness. The hospital is undertaking a review of the future definition of transplantation (renal) services that we should provide.

Definition: Kidney transplant is at KGH is cadaveric only, and can only occur when a donor is presented and a patient match (within catchment area) is found. If there is no organ match then the organ is made available to the province and beyond. The activity is measured by the case (transplanted kidney). The cadaveric (deceased donor) transplantation of Kidney's is supported by the Trillium gift of life network, the provincial organ and tissue donation agency.

Target: Baseline 08/09: 10, Target 09/10: 9, Target 10/11: 9, Target 11/12: 9

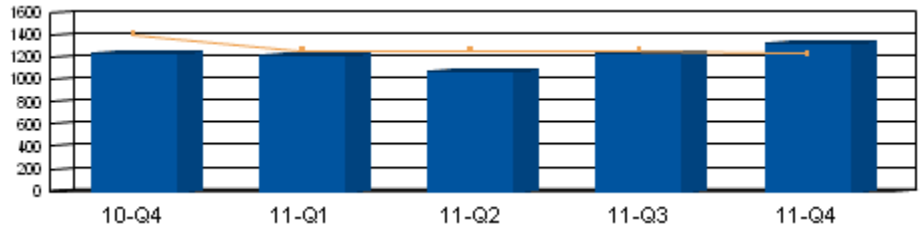
Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: MRI Hours (Wait Time Strategy Allocation)



	Actual	Target
10-Q4	1232	1405
11-Q1	1212	1259
11-Q2	1071	1259
11-Q3	1239	1259
11-Q4	1322	1228

Interpretation - Patient And Business:

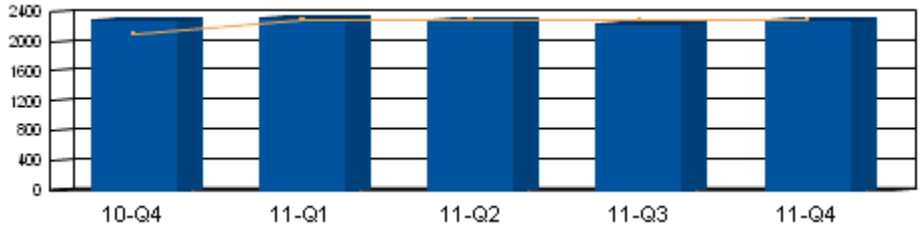
Recruitment of talented MRI staff instrumental in achieving this target. Extended hours on weekends and until midnight allowed for this target to be achieved. Our staffing model is hard on the technologists working in the area. They do work more hours alone than they should and the schedule is grueling at times. They were determined to achieve the hours this fiscal and they did. A 5th FT technologist is being recruited. This will allow for more flexibility in the schedule and will ensure the technologists do not work alone so much of the time. As a Director I would be hesitant to allow the technologists to take on a workload like the past fiscal again. With the recruitment of a 5th FT technologist the hospital will easily achieve the wait time hours and the staff will have a much healthier and safer work environment.

Reaching this goal has allowed more patients to access the MRI in a timely manner therefore supporting them in accessing the care required.

Definition: Wait Time Strategy (WTS) Allocation: In order to strategically increase service in select clinical services the Province has provided funds to support expanded volumes in some key areas. MRI Hours is one of the select areas. For the past few years the Province has offered funding to some hospitals on an annual basis to expand capacity of service. As hospitals already have funding for a base level of services, the additional incremental funding must be earned by expanding services beyond the base volumes. Given that KGH has been selected to provide additional volumes, our definition of this performance indicator is base volumes plus WTS Incremental cases plus any additional in-year SE LHIN volume adjustments.

Target: Baseline 08/09: 4627 hrs, Target 09/10: 4700 hrs, Target 10/11: 4700 hrs, Target 11/12: 5035 hrs.

Indicator: OR Cases (Inpatient and Outpatient))



	Actual	Target
10-Q4	2296	2098
11-Q1	2318	2286
11-Q2	2274	2286
11-Q3	2234	2286
11-Q4	2290	2286

Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: Described as the total number of inpatient and outpatient cases in the operating room (OR).

Target: Baseline 08/09: 8488, Target 09/10: 8390, Target 10/11: 8390, Target 11/12: 9145

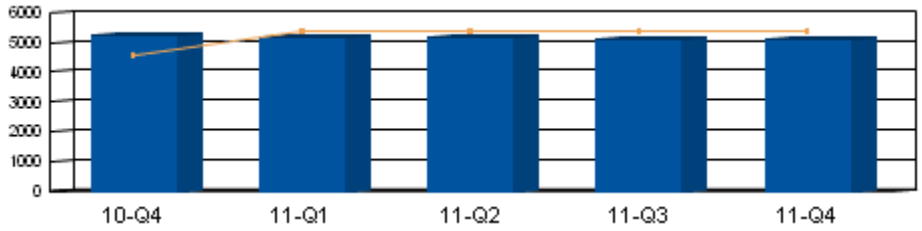
Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: OR Hours (Inpatient & Outpatient)



	Actual	Target
10-Q4	5217	4537
11-Q1	5146	5345
11-Q2	5145	5345
11-Q3	5104	5345
11-Q4	5088	5345

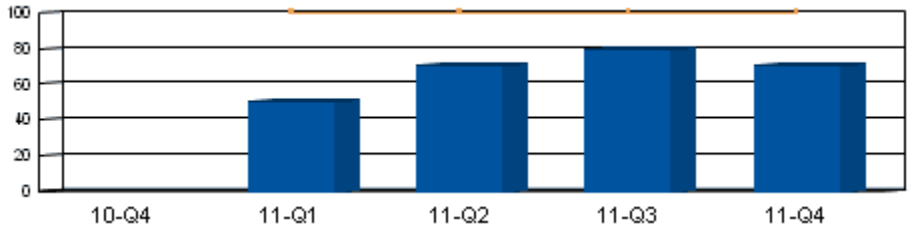
Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 4 quarters and requires no progress comment.

Definition: Operating room (OR) hours is described as the total inpatient and outpatient operating room hours staffed and available in the operating room.

Target: Baseline 08/09: 21143, Target 09/10: 18148, Target 10/11: 18148, Target 11/12: 21378

Indicator: Percent of Wait Time Contracted Volumes Achieved



	Actual	Target
10-Q4		
11-Q1	50	100
11-Q2	70	100
11-Q3	80	100
11-Q4	70	100

Interpretation - Patient And Business:

As of Q4, there were 3 incremental volume contracts that were not on target (ventral hernia, total joint replacements, and MRI hrs). It is important to note that during Q4, incremental volumes for both hernia repair and total joint replacements were returned to the SE LHIN for redistribution. As a result, there is no financial penalty to the hospital. In the case of MRI hrs, despite the Q4 target being achieved the yearend target was missed just 56 hrs or 1.4%. This was due to staffing shortfalls in the early part of the year that have since been rectified.

Actions & Monitoring Underway to Improve Performance:

The Wait List Management Committee and the Surgical Program closely monitoring these issues.

Definition: In order to strategically increase service in select clinical services, the Province has provided incremental funds to support expanded volumes. As hospitals already have funding for a base level of services, the additional incremental funding must be earned by expanding services beyond these base volumes. Given that KGH has been selected to provide additional volumes in many different areas, our definition of this performance indicator is dividing the number of incremental volume contracts on target by the total number of contracts expressed as a percent. It is intended to provide an overall view of progress with respect to meeting MOH volume contracts.

For F2012: Intestinal IP, Groin Hernia, Ventral Hernia,Oral Maxiofascial (Dental), Scoliosis,MRI, CT,Total Joints, Cancer Surgery, Cardiac

Target: Target 11/12: 100%

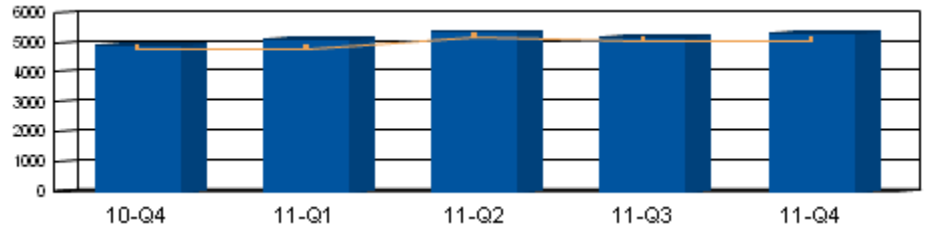
Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: Total Inpatient Admissions



	Actual	Target
10-Q4	4925	**4782**
11-Q1	5082	**4782**
11-Q2	5345	**5195**
11-Q3	5204	**5055**
11-Q4	5332	**5058**

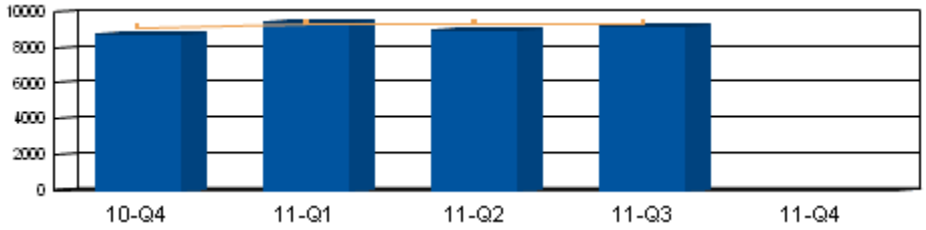
Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: Total number of admissions to inpatient wards is a measure of total inpatient activity in the hospital.

Target: Baseline 08/09: 19464, Target 09/10: 19400, Target 10/11: 19400, Target 11/12: 20,500

Indicator: Total Inpatient Weighted Cases



	Actual	Target
10-Q4	8710	**9103**
11-Q1	9363	**9326**
11-Q2	9014	**9326**
11-Q3	9207	**9326**
11-Q4		

Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: Total Inpatient Weighted Cases is a measure of total inpatient output of the hospital. By converting cases to a normalized measure using case Resource Intensity Weights (RIW) a common overall measure of output is produced.

RIW methodology is a relative resource allocation tool for estimating a hospital's inpatient-specific resource consumption. RIWs are used to standardize the expression of hospital case resource consumption, recognizing that not all patients require the same health care resources. Total resource consumption is then expressed as "weighted cases".

Target: Baseline 08/09: 35291, Target 09/10: 35300, Target 10/11: 35300, Target 11/12: 34616

Strategy milestone # 14

KGH clinical staff adopt evidence-based guidelines in 6 clinical areas

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Increase our focus on complex-acute and specialty care	Best evidence used to guide practice	Increase adoption of clinical practice guidelines

Indicator(s)	Status
Number of Clinical Areas That Have Implemented Open Source Order (OS)	Green

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   Six of the 6 planned clinical areas achieved implementation of at least one order set.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The Order Set Committee and working group were active in engaging programs and clinical services in development of order sets.

3. **Are we on track to meet the milestone by year end?**
   This milestone met the Q4 and year end target.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**

   The benefits to patient safety and quality of care are expected by using best practice/evidence based templates to ensure appropriate treatments, medications and investigations. Expansion to other clinical areas is planned.

Milestone #14

				10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
SD4 Increase our focus on complex-acute	KGH clinical staff adopt evidence-based guidelines		Number of Clinical Areas that have Implemented Open Source (OS)	N/A	G	R	G	G	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

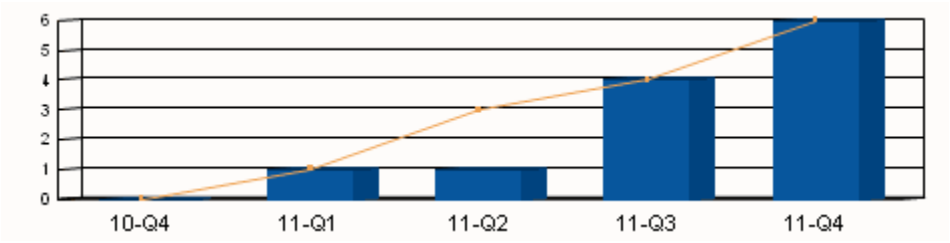
Kingston General Hospital

Milestone #14

SD4 Increase our focus on complex-acute and specialty care

KGH clinical staff adopt evidence-based guidelines in 6 clinical areas

Indicator: Number of Clinical Areas that have Implemented Open Source (OS)



	Actual	Target
10-Q4	0	**0**
11-Q1	1	**1**
11-Q2	1	**3**
11-Q3	4	**4**
11-Q4	6	**6**

Interpretation - Patient And Business:

An order set is a group of comprehensive, best practice/evidence-based practitioner orders that assist healthcare providers to manage common healthcare issues and interventions/procedures in a variety of patient populations. The benefits to patient safety and quality of care are expected by using best practice/evidence based templates to ensure appropriate treatments, medications and investigations. Reduced length of stay and readmission rates are also expected to be supported with use of Order Sets.

Actions & Monitoring Underway to Improve Performance:

As of Q4, 6 of the 6 planned clinical areas had achieved Implementation with a total of 12 order sets in place. Critical Care has 5 Cardiovascular Surgery has 3, OB/Gyn has 1, ER/SADV has 1, Sleep Lab has 1, and General Surgery has 1.

Definition: Clinical Areas - Generally defined as the programs. However, SPA and Medicine are too large. These programs will be divided by service areas. Several areas fall outside of the program structure and these will be defined by group e.g. Allied Health, Diagnostic Imaging

Adoption – order set development and approval by MAC

Target: Target 11/12: 6

Strategy milestone # 15

Average sick days per KGH employee are reduced to 10.5

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
People	KGH is designated as one of the best places to work	Launch our staff scheduling system

Indicator(s)	Status
Launch a Staff Scheduling Project	Green
Average sick days per eligible employee per year	Yellow

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   Project manager seconded in March 2012 to launch initiative. Sick time rolling average was 11.42 in March, down from January and February at 11.49. The lowest rolling average in this fiscal was 10.77 in July. Although the rolling average is holding steady, each year end has seen progress over the previous number of incidents and average incidents continue to reduce overall.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Sick time: February saw some encouraging improvements; however March saw all groups with slight increases in absenteeism. All groups except for OPSEU 450 are still lower than January, though CUPE remains the highest. ONA has a rolling average of 13.50 which is the best to recorded to date and better than benchmarked averages. The number of times staff are off sick has reduced, the challenge remains with the duration of each incident of sick time.

3. **Are we on track to meet the milestone by year end?**
   The target of 10.5 average sick date will not be achieved this fiscal year.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Sick time performance posters for Q4 by department to be distributed in May. Attendance awareness blitz with managers and continued focus on disability management and new focus on wellness for the upcoming fiscal year.

Kingston General Hospital

Milestone #15

				10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
E1 People	Average sick days per KGH employee are reduced to 10.5		Average Sick Days per Eligible Employee per Year	Y	Y	Y	Y	Y	↓
			Launch the Staff Scheduling Project	N/A	G	R	N/A	G	↑
			Percent of Overtime Hours	Y	Y	Y	Y	Y	↓
			Percent Sick Time Hours	G	Y	Y	Y	Y	↓
			Total Full Time Equivalents (FTEs)	Y	G	G	G	G	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

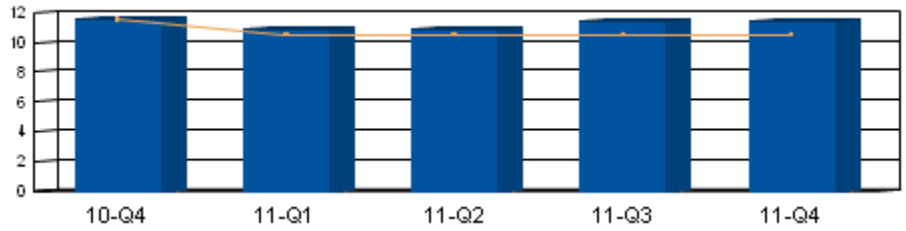
Kingston General Hospital

Milestone #15

E1 People

Average sick days per KGH employee are reduced to 10.5

Indicator: Average Sick Days per Eligible Employee Per Year



	Actual	Target
10-Q4	11.6	11.5
11-Q1	10.9	10.5
11-Q2	10.9	10.5
11-Q3	11.4	10.5
11-Q4	11.4	10.5

Interpretation - Patient And Business:

The rolling average was 11.42 at the end of the quarter. The lowest month to date in the fiscal year was 10.77 (July, 2011). February saw some encouraging improvements; however March saw all groups with slight increases in absenteeism.

The average and median number of incidents are at the lowest level since we have been recording sick time in this way (1999). ONA has a rolling average of 13.50 continuing to best any previous recorded average number and is better than the benchmarked averages. The OHA last absence survey overall average for nurses was 13.69 and for acute teaching hospitals it was 13.98.

Actions & Monitoring Underway to Improve Performance:

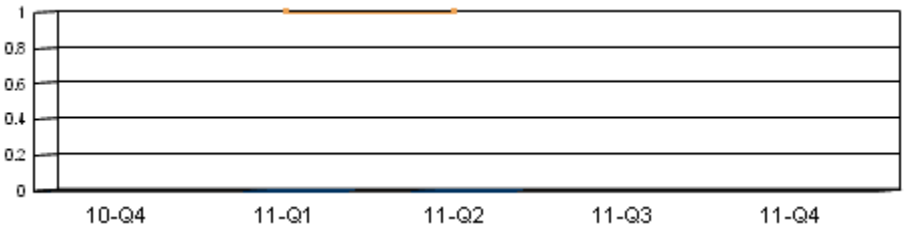
We have been very successful at reducing the frequency of sick incidences due to the focus on attendance management, following the HOODIP plan guidelines, changes in the collective agreements (ONA, OPSEU), and appropriate adjudication. Although the number of times staff are off sick has reduced, the challenge remains now with the duration of each incident of sick time.

Healthy Workplace Services will be conducting a 'sick time blitz' in May The timing is key due to the introduction of all part time staff to the attendance program and in advance of the summer vacation season which typically sees sick time also increase. A focused session on sick time with union presidents will occur in April and a new sick time poster by the end of April.

Definition: The average sick days per eligible employee tracks all sick time of an employee on a twelve month rolling basis. Employees included are all active employees, eligible for paid sick time, as at the last day of the last calendar month of the twelve month period. Active employees include employees on leave of absence. It does not include employees who have terminated, retired or transferred to part-time positions during the twelve month period reported. The average is calculated based on total sick hours for all employees eligible for paid sick time divided by the total number of active employees, eligible for paid sick time as at the last day of the month. A day is based on 7.50 hours. The corporate goal is to reduce the average sick time to the Human Resources Benchmarking Network (HRBN) average for the healthcare sector in Ontario.

Target: Baseline 08/09: 14.03, Target 09/10: 12, Target 10/11: 11.5, Target 11/12: 10.5

Indicator: Launch the Staff Scheduling Project



	Actual	Target
10-Q4		
11-Q1	0	1
11-Q2	0	1
11-Q3		
11-Q4		

Definition: The purpose of the scheduling project is to increase efficiencies through standard processes, centralized scheduling and deployment of updated technologies to create capacity for frontline managers and staff. The improvement of staff scheduling against union contracts across the hospital will decrease sick time and overtime payments. This project will leverage the current workforce scheduling software that has already been procured at the hospital to gain these efficiencies. The measurement is that the project will be in its configuration stage by March 2011.

Target: Target 11/12: Yes

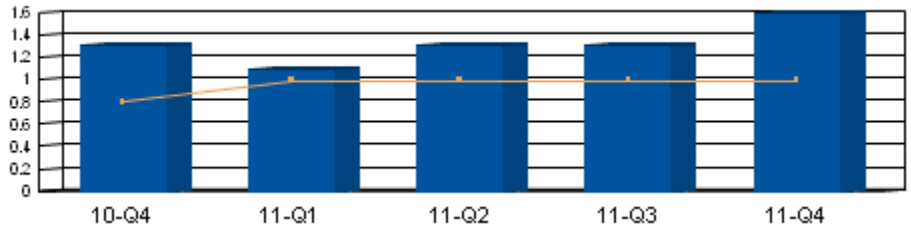
Kingston General Hospital

Milestone #15

E1 People

Average sick days per KGH employee are reduced to 10.5

Indicator: Percent of Overtime Hours



	Actual	Target
10-Q4	1.30	0.80
11-Q1	1.10	0.99
11-Q2	1.30	0.99
11-Q3	1.30	0.99
11-Q4	1.60	0.99

Interpretation - Patient And Business:

Overtime hours and dollars were in a negative variance position for this quarter. The largest variances for March included Surgery and Pediatrics, as well as those areas with staffing needs such as Nutrition, and Critical Care.

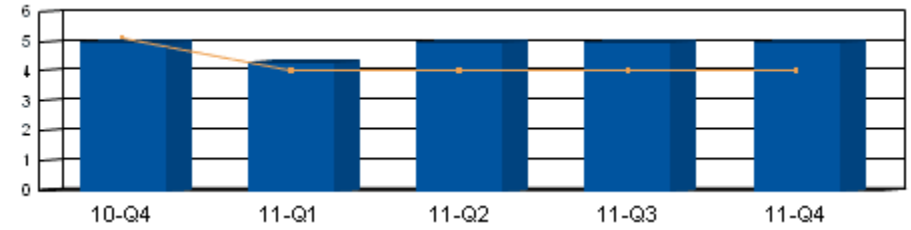
Actions & Monitoring Underway to Improve Performance:

A recruitment and orientation strategy has been established for Critical Care where there has been a shortage of RNs. It is anticipated as more come on staff and are trained in Q1 of the upcoming year it will assist in the overtime issues. This will also be needed to ensure adequate vacation coverage for the summer season. Nutrition Services is also in the process of hiring more staff.

Definition: This is a Hospital Annual Planning Submission (HAPS) indicator that covers full-time staff. This indicator measures the percentage of overtime hours worked by all employees (i.e. not including purchased services) compared to the total hours worked.

Target: Baseline 08/09: 1.9%, Target 09/10: 0.8%, Target 10/11: 0.8%, Target 11/12 0.99%

Indicator: Percent Sick Time Hours



	Actual	Target
10-Q4	5	5
11-Q1	4	4
11-Q2	5	4
11-Q3	5	4
11-Q4	5	4

Interpretation - Patient And Business:

The number of sick time hours for the quarter was in a negative variance for hours and dollars. Pharmacy, Material Management, Supply Chain, and Medicine saw some of the largest variances of sick time hours for March. The number of sick time hours for the past fiscal year was 188,043.54 hours.

Actions & Monitoring Underway to Improve Performance:

The number of times staff is off sick has reduced, but the challenge remains with the duration of each incident of sick time. We are getting down to the illnesses that are more serious for sick time utilization which increases the need to continue to focus on disability management and return to work. Healthy Workplace Services (HWS) will be conducting a 'sick time blitz' in May. We are reviewing schedules of the high CUPE positions for sick time to determine if change could improve sick time.

Definition: This is a Hospital Annual Planning Submission (HAPS) indicator that measures the percentage of sick time provided by full-time employees. Full-time employees are defined as those employment statuses that are full-time, part time temporary full-time or job sharing, and casual temporary full time. Occupational groups include Management & Operational Support (M&OS), Unit Producing Personnel (UPP), and Nurse Practitioner (NP).

Target: Baseline 08/09: 6.6%, Target 09/10: 5.2%, Target 10/11: 5.1%, Target 11/12 4.0%

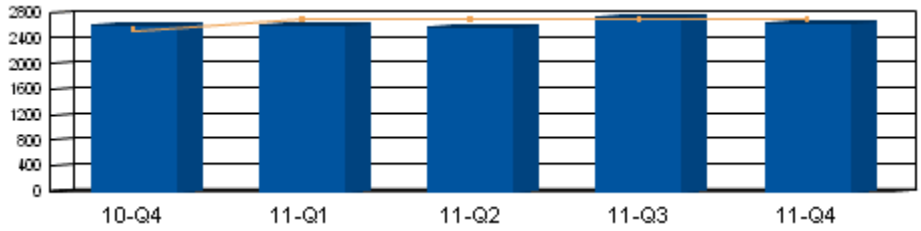
Kingston General Hospital

Milestone #15

E1 People

Average sick days per KGH employee are reduced to 10.5

Indicator: Total Full Time Equivalents (FTEs)



	Actual	Target
10-Q4	2601	**2515**
11-Q1	2613	**2687**
11-Q2	2566	**2687**
11-Q3	2718	**2687**
11-Q4	2643	**2687**

Interpretation - Patient And Business:

Multiple vacancies and difficulty finding replacements impacts the FTE count vs. budgeted FTEs. Overtime and sick time rates remain constant.

Actions & Monitoring Underway to Improve Performance:

Increased recruitment resources for Q1 2013 to fill vacancies in a more timely manner.

Definition: This is a Hospital Annual Planning Submission (HAPS) indicator. This indicator measures the average number of unit-producing and management operational & support full-time equivalents (FTEs) in the facility in a given period. FTEs are calculated by total earned hours divided by FTE hours (1950 hours). FTE counts provide a common denominator in which to measure total hours e.g. KGH could have 4000 employees but they equate to only 3200 FTEs while another hospital may have only 3700 employees but their total FTEs equals 3100 employees.

Target: Baseline 08/09: 2648, Target 09/10: 2566 , Target 10/11: 2515, Target 11/12: 2687

Strategy milestone # 16

Lost time injury claims are reduced by 10%

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
People	**All preventable harm to staff is eliminated**	**Improve workplace safety**

Indicator(s)	Status
Lost time injury claims	**Red**

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   While lost time injury claims is red, it is 2 injuries above the target. This has been mitigated with 20 individuals receiving modified duties. Needlestick injuries is on target while Musculoskeletal injuries (MSI) remains steady from previous quarter and continue to be significantly above the target. Incident investigations by managers is down, although finished the fiscal year improved from last year.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   MSI have shifted from previous fiscal year of 60% related to patient care handling to 40%, while the remainder being other in this fiscal year. There has been an increase in support services areas, for example Environmental Services at 23%.

3. **Are we on track to meet the milestone by year end?**
   We are not on track for this fiscal year end.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   There has been training for managers, roll-out of Safety and Wellness Boards to bring awareness to frontline staff and the monthly management inspections program was implemented late in 2011 with ongoing training in Q4 to reinforce that key injury prevention are these inspections. These sessions also highlighted the need for departments to support the immediate provision of modified/suitable work to avoid LTI claims.

Kingston General Hospital

Milestone #16

				10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
E1 People	Lost time injury claims are reduced by 10%		Lost Time Injury Claims	N/A	Y	Y	Y	R	↓
			Musculoskeletal Injuries (MSIs)	R	G	R	R	R	↑
			Percent Completion of Incident Investigations	R	R	R	Y	R	↓
			Reduction in Lost Time Injury Claims due to Musculoskeletal Injuries	N/A	R	R	Y	R	↓
			Reduction in Needle Stick Injuries	N/A	R	Y	R	G	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

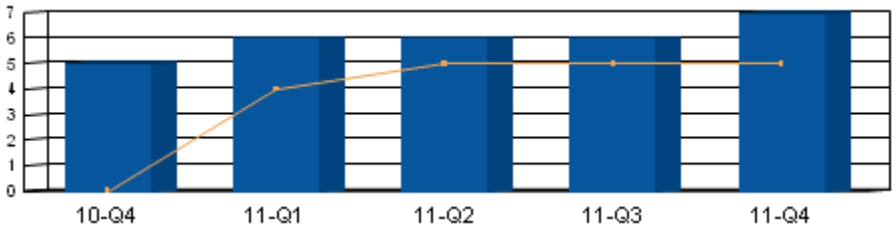
Kingston General Hospital

Milestone #16

E1 People

Lost time injury claims are reduced by 10%

Indicator: Lost Time Injury Claims



	Actual	Target
10-Q4	5	0
11-Q1	6	4
11-Q2	6	5
11-Q3	6	5
11-Q4	7	5

Interpretation - Patient And Business:

The number of LTIs per quarter remains relatively consistent. Causes of LTIs in Q4 were as follows: 1 fall, 1 slip, and 5 were due to musculoskeletal injury (MSI). 2 LTIs occurred in the critical care program and in 2 of our LTIs equipment failure was a contributing factor. The LTI that occurred as a result of a fall resulted in several weeks of lost time into the month of April. Additional lost time injuries were avoided in Q4 through the provision of 198 modified work days to 20 employees.

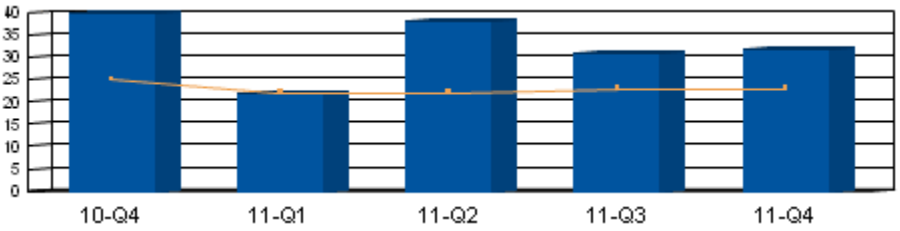
Actions & Monitoring Underway to Improve Performance:

The Management Inspection Program, which was implemented late in 2011 and reinforced in Q4, is a key injury prevention strategy targeted at reduction in our LTI incidence. Leadership sessions in Q4 highlighted the need for depts to support the immediate provision of modified/suitable work to avoid incurring LTI claims.

Definition: Workplace injuries that result in a worker being unable to report to work, even in a modified capacity, are a measure of the severity of injury incurred. Hospitals are benchmarked against one another by the WSIB according to lost time injury (LTI) frequencies. LTI frequency and severity (total days per claim) are the key metrics used for selecting organizations to participate in health & safety improvement initiatives such as workwell audits and targeted intervention by the Ministry of Labour (MOL). It is LTI's that result in the majority of our WSIB claim costs. Reducing LTI's means substantial savings on the NEER statement and the potential for year end rebates rather than surcharges.

Target: Target 11/12: 19 (10% reduction from fiscal 10/11)

Indicator: Musculoskeletal Injuries (MSIs)



	Actual	Target
10-Q4	40	25
11-Q1	22	22
11-Q2	38	22
11-Q3	31	23
11-Q4	32	23

Interpretation - Patient And Business:

The number of MSI incidents in Q4 was similar to Q3. Of the 32 incidents, 31% (N= 10) were related to patient handling activities (lifting, transferring, repositioning), and 69% (N= 22) were due to all other causes (MSI -Other). Whereas 60% of MSIs were due to patient handling last fiscal, we have seen a reversal in this trend in 2011/12 with only 41% directly related to patient handling and 59% related to all other causes. The areas with highest incidence of MSIs in Q4 were: Environmental Services (25%), Medicine Program (18%), and the Critical Care program (18%).

Actions & Monitoring Underway to Improve Performance:

The reduction in patient handling-related MSIs may be indicative of increased use by clinical staff of assistive devices for patient handling. Following an evaluation of the MSI prevention program in Q2 of the upcoming year, recommendations for program improvement will made. OHSW currently recruiting for Part-time Ergonomist to lead this prevention initiative.

Definition: MSI rate is a measure of health & safety performance and linked to Ministry of Labour (MOL) involvement and Workplace Safety & Insurance Board (WSIB) costs. The MSI measure is divided into 1-MSI's related to patient handling and 2- MSI's other. MSI's are tracked monthly. Based on the premise that workplace injuries are preventable, they are unacceptable and our long term goal should be "zero" MSIs. MSIs are the type of injury that most often result in delayed recovery & permanent limitations.

Target: Baseline Fiscal 08/09: 150, Target 09/10: 100, Target 10/11: 100, Target 11/12: 90

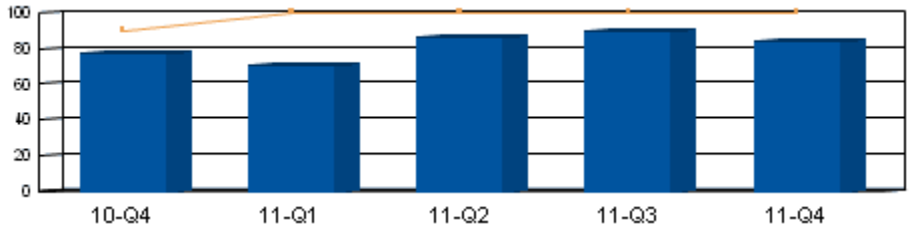
Kingston General Hospital

Milestone #16

E1 People

Lost time injury claims are reduced by 10%

Indicator: Percent Completion of Incident Investigations



	Actual	Target
10-Q4	77	90
11-Q1	70	100
11-Q2	86	100
11-Q3	90	100
11-Q4	84	100

Interpretation - Patient And Business:

Some decline this quarter in completion of investigations.

Actions & Monitoring Underway to Improve Performance:

"Healthy Workplace & Safety Updates" sessions that were provided in February to 70 Leaders reviewed Incident Investigation accountabilities. Occupational Health & Safety memo goes to Manager if investigation not initiated within 4 business days. Completion of Investigations now part of Leadership Performance Agreements

Definition: Investigating workplace incidents ensures due diligence in terms of identifying and resolving hazards that contribute to injuries. This is a legislative requirement under the Occupational Health & Safety Act (OH&S Act) and demonstrates our commitment as an organization in managing hazards and creating a work environment that is safe for staff and patients. Collecting & analyzing the underlying causes and putting in place correction actions/improvements is a key strategy in the elimination of all preventable harm. Calculation is based on the percentage of investigations completed as compared to those that were required. The goal for 2011 is for 100% of employee/affiliate general safety events submitted in Safe Reporting to be investigated by managers/supervisors.

Target: Baseline Fiscal 08/09: Between 20-30% of investigations are completed, Target Fiscal 09/10: 90% completion, Target Fiscal 10/11: 90% completion, Target 11/12: 100% completion

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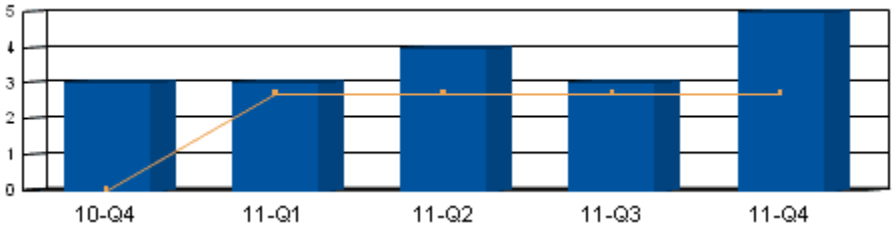
Indicator: Reduction in Lost Time Injury Claims due to Musculoskeletal Injuries



	Actual	Target
10-Q4	3	0
11-Q1	3	2.7
11-Q2	4	2.7
11-Q3	3	2.7
11-Q4	5	2.7

Interpretation - Patient And Business:

Q4 had the highest incidence of lost time injuries caused by musculoskeletal injury (MSI).
1 was related to patient handling and 2 involved the malfunction of wheeled equipment.

Actions & Monitoring Underway to Improve Performance:

Areas for further assessment in 2012/13 are 1- preventive maintenance process for wheeled equipment and 2- the use of disposable transfer board sleeves

Definition: Musculoskeletal Injuries (MSIs), as a main cause of lost time injuries, result in the highest workplace injury costs. MSIs often result in delayed recovery, long periods of modified/alternate work, permanent accommodation, or an inability to return to employment at the hospital. Reduction in MSI's that result in lost time will reduce the hospital's injury costs and avoid the negative repercussions to the employee & their unit/dept that are associated with a reduced ability to function in the workplace.

Target: Target 11/12: 10.8

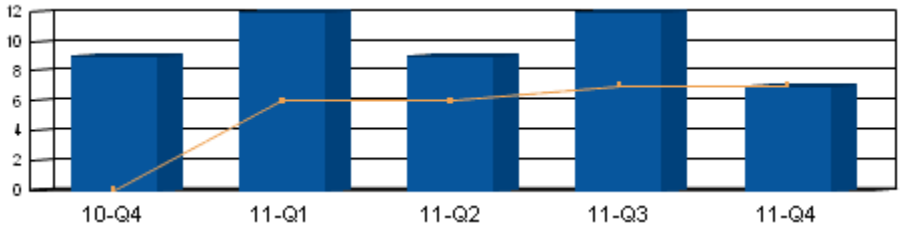
Kingston General Hospital

Milestone #16

E1 People

Lost time injury claims are reduced by 10%

Indicator: Reduction in Needle Stick Injuries



	Actual	Target
10-Q4	9	**0**
11-Q1	12	**6**
11-Q2	9	**6**
11-Q3	12	**7**
11-Q4	7	**7**

Interpretation - Patient And Business:

Q4 saw a reduction in NSIs and our lowest incidence to date. Nearly 60% of the injuries occurred in the SPA program. In all but 1 injury, improper activation of the safety needle or technique was the contributing factor.

Actions & Monitoring Underway to Improve Performance:

One injury was related to the current butterfly used for venipuncture and a proposal for conversion to a safer butterfly device (push button) has been proposed. Investigation of NSIs will be key in identifying and addressing factors contributing to NSIs.

Definition: Needlestick injuries are one of the indicators used to measure the success of KGH's sharps management program. The incidence is also used by the Ministry of Labour to determine whether the hospital is putting in place adequate controls to protect workers from the risk of blood-borne pathogens. Each year thousands of health care workers sustain needlestick injuries in Canada; each one of these injuries carries the risk of exposure to serious and even potentially fatal infections with bloodborne pathogens such as HBV, HCV or HIV. Analysis of needlestick injury data, investigation of all needlestick injuries, and implementation of corrective measures/improvements will result in safer use of medical sharps and a reduced risk of serious occupational disease claims.

Target: Target 11/12: 26

Strategy milestone # 17

100% of our staff complete mandatory online training

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
People	**Staff are engaged in all aspects of our quality, safety and service improvement initiatives**	**Enhance our leadership and learning programs**

Indicator(s)	Status
Percent of Staff that Complete Mandatory Online Training Programs	**Yellow**

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   Overall completion rate increased from 91.5 at end of December to 94.9% at the end of Q4 which translates to approximately 3300 staff having completed 4 modules of online training.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Leaders are continued to reminded regarding the importance of compliance with the majority of leaders following up as required. Some areas, where computer use is not part of the norm, i.e. Environmental Services, appear to be short of the targets. Full roll-out of the online Learning Management System enables accurate record keeping and alerts to individuals who required refreshers.

3. **Are we on track to meet the milestone by year end?**
   Green will not be achieved as 100% in each quarter is challenging whereby there is a constant churn of new hires and individuals becoming due to refreshers.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**

   Continue to work with areas that appear to have challenges to achieve the target and explore other mechanisms for sustainment.

Kingston General Hospital

Milestone #17

				10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
E1 People	100% of our staff complete mandatory online training		Percent of Staff that Complete Mandatory Online Training Programs	N/A	R	Y	Y	Y	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

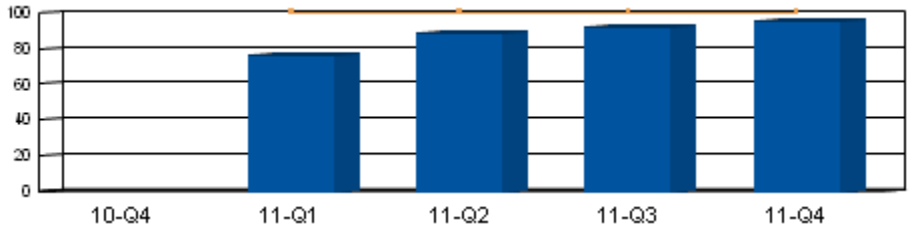
Kingston General Hospital

Milestone #17

E1 People

100% of our staff complete mandatory online training

Indicator: Percent of Staff that Complete Mandatory Online Training Programs



	Actual	Target
10-Q4		
11-Q1	76	**100**
11-Q2	88	**100**
11-Q3	92	**100**
11-Q4	95	**100**

Interpretation - Patient And Business:

Improvement continues in each quarter with a 25% increase overall since Q1 2012. Staff are becoming more comfortable logging into and navigating the LMS. PSOE continues to provide support in areas where computer work is not a normal task in the daily work environment. Sessions are well received and should contribute to a continued increase in compliance rates.

Actions & Monitoring Underway to Improve Performance:

Continued emphasis on the importance and legal requirement for mandatory training completion. Direct leaders should consider direct report completion rates as an element of their annual performance assessments for April 1, 2012.

Definition: Currently, mandatory training includes Incident Reporting, Accessibility, WHIMS and Musculoskeletal Injury reporting. The Learning Management System (LMS) is being upgraded and enhanced to allow all staff access to mandatory training on-line. Functionality is such that managers can obtain timely reports on the status of compliance for each employee. This will increase the opportunities for following up and ensuring supports are put in place to permit employees to complete required training. Further training I enhancements will be put into place (e.g., on-line General Orientation, on-line On Boarding modules, tracking of refresher requirements) to ensure on-going mandatory training and re-training occurs at times convenient to the employee.

Target: Target 11/12: 100%

Strategy milestone # 18

100% of our KGH managers complete mandatory process improvement training

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
Processes	**Continuous improvement environment created with consistent use of LEAN principles**	**Increase LEAN process adoption**

Indicator(s)	Status
Percent of Management Staff that Complete Mandatory Process Improvement Training	**N/A**

Was postponed until fiscal 2012/13

VP People Services
Q4 2011-12

Kingston General Hospital

Milestone #18

				11-Q1	11-Q2	11-Q3	11-Q4
E2 Processes	100% of KGH managers complete mandatory process		Percent of Management Staff Completing Mandatory Process Improvement Training	Y	R	N/A	N/A

Indicates improving performance to target over the past 5 quarters 

Indicates worsening performance to target over the past 5 quarters 

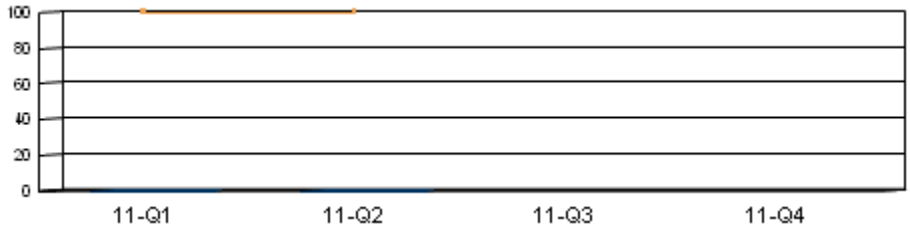
Kingston General Hospital

Milestone #18

E2 Processes

100% of KGH managers complete mandatory process improvment training

Indicator: Percent of Management Staff Completing Mandatory Process Improvement Training



	Actual	Target
11-Q1	0	**100**
11-Q2	0	**100**
11-Q3		
11-Q4		

Definition: Introduction of lean principles to the KGH Leadership Group will enable a focus on long-term sustainability with a comprehensive approach to change. It will drive operational efficiency and cultural change at the same time. It provides tools for the managers to use and a consistent approach on how we expect the organization to be run. The measurement will be a percentage of our KGH Leadership Group (non-physician) who attends the training.

Target: Target 11/12: 100 %

Strategy milestone # 19

96% of our Phase 1 redevelopment is complete on time, on budget and new retail and nutrition facilities are in place

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
Facilities	Phase 1 redevelopment is complete, Phase 2 construction is underway and KGH has sufficient parking	Complete Phase 1 redevelopment and establish new retail and food service facilities

Indicator(s)	Status
Redevelopment (Space for New Clinical, Retail, Nutrition Facilities)	Green (complete)
Phase 1 Redevelopment is Completed on Time and on Budget	Green
Phase 2 Redevelopment Planning Started	Green

1. **What is our actual performance on each of the indicators for this milestone as listed above?**

   Performance on these indicators is all good news at this point. We had very busy year in constructing new space, bring closure to Phase 1, and working no Stage 1 planning for Phase 2. Retail and Nutrition space is all open on schedule, we are in progress of final deficiency and clean up on Phase 1. Phase 2 planning has progressed as planned, however the logistics required to consult with regional hospitals, the university and other stakeholders we have determined will move completion of Stage 1 to the fall.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**

   JPO staff are now completing the final steps in Phase 1. Phase 2 is under the supervision of a Steering Committee which is monitoring progress.

3. **Are we on track to meet the milestone by year end?**

   Yes

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**

   Phase 2, Stage 1 documentation was originally planned to be submitted by June 30, 2012. Time line is now projecting October 2012. The factors contributing to the new time line include: the completion of update of the master plan/program documentation has required additional time to engage the organization, partners, and region. In addition the complexity of achieving consensus on the fund raising plans and completing planning with the University on the use of the Etherington building site will take longer to work through each organizations governance processes. The Phase 2 Steering Committee is overseeing the progress on these plans. Resources are in place to support document preparation and senior leadership and staff are engaged with our partners to complete the required approvals for the submission.

Kingston General Hospital

Milestone #19

				10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
E3 Facilities	96% of our Phase 1 redevelopment is complete on time, on budget, and new retail and nutrition facilities are in place		Phase 1 Redevelopment is Completed on Time and On Budget	N/A	G	G	G	N/A	↑
			Phase 2 Redevelopment Planning Started	N/A	G	Y	G	N/A	↑
			Redevelopment (Space for new Clinical, Retail, Nutrition Facilities)	N/A	G	G	G	N/A	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

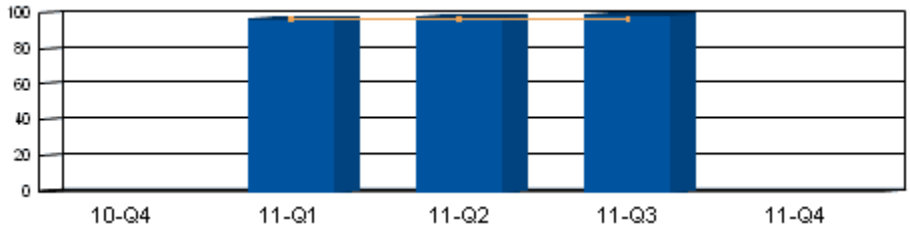
Kingston General Hospital

Milestone #19

E3 Facilities

96% of our Phase 1 redevelopment is complete on time, on budget, and new retail and nutrition facilities are in place

Indicator: Phase 1 Redevelopment is Completed on Time and On Budget

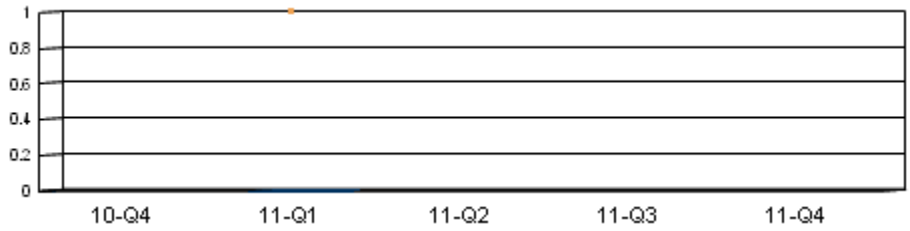


	Actual	Target
10-Q4		
11-Q1	96	**96**
11-Q2	97	**96**
11-Q3	99	**96**
11-Q4		

Definition: Project completed by 2012 March within the budget of $196M.

Target: Target 11/12: 96%

Indicator: Phase 2 Redevelopment Planning Started

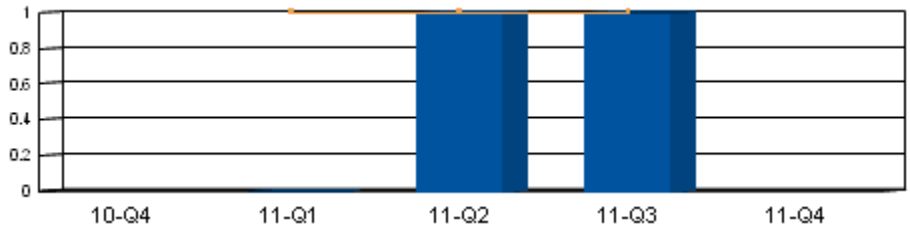


	Actual	Target
10-Q4		
11-Q1	0	**1**
11-Q2		
11-Q3		
11-Q4		

Definition: MOHLTC responded to precapital submission for Phase 2 Redevelopment and granted approval for preparation of Stage 1 proposal.

Target: Target 11/12: Yes

Indicator: Redevelopment (Space for new Clinical, Retail, Nutrition Facilities)



	Actual	Target
10-Q4		
11-Q1	0	**1**
11-Q2	1	**1**
11-Q3	1	**1**
11-Q4		

Definition: Phase I Redevelopment remains on schedule with substantial completion was achieved on 2011 December 22. Retail project has received approval from MoHLTC and construction has begun.

Target: Target 11/12: Yes

Strategy milestone # 20

Our new solar farm is established and 50% of carpets are removed from inpatient areas

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
Facilities	KGH is clean, green and carpet-free	'Green' KGH by conserving energy and removing carpets from inpatient areas

Indicator(s)	Status
Percent of Square Footage of Carpet Removal Complete	Green
Solar Farm Established	N/A

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   Carpet removal is progressing as planned and we achieved the 40 percent removal target against plan as of March 31, 2012.
   The solar project as at year end was still on hold pending the provincial plans for new rates and rules for projects.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The carpet removal relies heavily on both clinical staff and capacity to realign workload and support staff capacity to move the physical structures. The work is very difficult and disruptive, however all staff have work hard to make the moves and renovations go smoothly. The coordination by both clinical and support staff and leadership has been excellent. For solar as noted above we await new rules that are expected in June 2012. At that time we will redo the business case to determine if we are still able to complete the project**.**

3. **Are we on track to meet the milestone by year end?.**
   Carpet milestone for 2012 was met.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   We are now aiming for a 2013 milestone of 70 percent carpets removed from clinical areas by March 31, 2013 and the approach that has been successful in 2012 will remain in place. JPO is coordinating the carpet removal plans with all support and clinical areas. Facilities leadership are overseeing the Honeywell Project that contains the Solar Project and are monitoring to advance as soon as information is ready to update the business plan (this will come back to the Resource Committee of the Board as soon as available).

Kingston General Hospital

Milestone #20

				10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
E3 Facilities	Our new solar farm is established and 50% of carpets are removed from inpatient areas		Percent of Square Footage of Carpet Removal Complete	N/A	G	G	G	G	↑
			Solar Farm Established	N/A	Y	R	R	N/A	↓

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

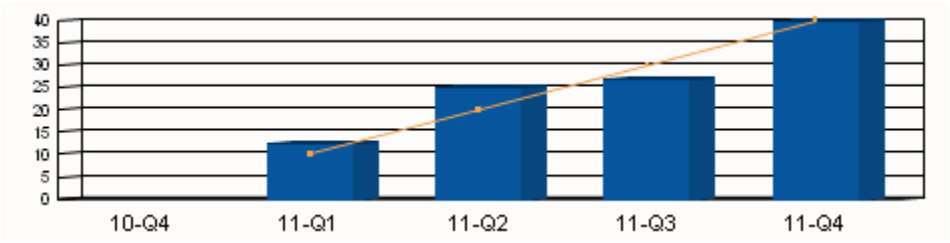
Kingston General Hospital

Milestone #20

E3 Facilities

Our new solar farm is established and 50% of carpets are removed from inpatient areas

Indicator: Percent of Square Footage of Carpet Removal Complete

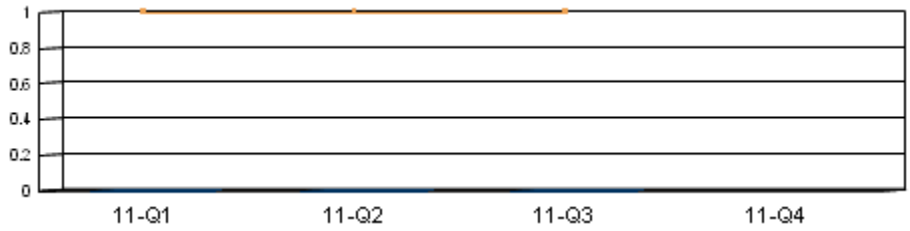


	Actual	Target
10-Q4		
11-Q1	13	**10**
11-Q2	25	**20**
11-Q3	27	**30**
11-Q4	40	**40**

Definition: Phase 1 A equals 14% Phase 1 B equals 37% and Phase 2 equals 49% of total $7M project.

Target: Target 11/12: 40%

Indicator: Solar Farm Established



	Actual	Target
11-Q1	0	**1**
11-Q2	0	**1**
11-Q3	0	**1**
11-Q4		

Definition: A 110 kW solar farm is proposed for the roof of Burr Wing. 468 solar panels will be connected to the City of Kingston utility grid and will generate guaranteed revenue of $86,841 for 20 years through a contract with the Ontario Power Authority. Before installing the solar panels, the application must be approved by the Ontario Power Authority. Current processing times are estimated at 7 months. The KGH application is not expected to be approved until fall 2011 following which detailed engineering and installation to be complete by the end of 2012. Measurement of completion of this outcome will be based on the % completion of the project.

Target: Target 11/12: Yes

Strategy milestone # 21

50% of our automated medication dispensing system is in place

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
Technology	**Rapid transmission of information improves care and operational efficiency**	**Enable automated medication dispensing**

Indicator(s)	Status
Automated Medication Dispensing System in Place Throughout Inpatient Units Within the Hospital	**Green**

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   The RFP was completed by March 31, 2012 as planned. We are now in the process of acquiring approvals for the award of the contract. This should be completed in May 2012. We are on schedule.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   We had a lot of support from several key departments to support the completing of the RFP. This is a large investment and leadership/staff from Pharmacy, 3SO, Finance, JPO, and Information Management, and Decision Support have all played significant roles in moving this forward. Negotiations were lengthy and detailed.

3. **Are we on track to meet the milestone by year end?**
   Yes

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   All approvals are in place to move forward, and we are just completing the due diligence at Operations Committee to make sure the financial capacity is still available to support the capital allocations originally planned. The 2013 capital and operational budgets are being realigned to reflect the recent changes in the provincial funding model. This work is expected this will be done in May 2012.

Kingston General Hospital

Milestone #21

				11-Q1	11-Q2	11-Q3	11-Q4	
E4 Technology	50% of our automated medication dispensing system in place		Automated Medication Dispensing System in Place Throughout Inpatient Units Within the Hospital	G	R	N/A	G	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

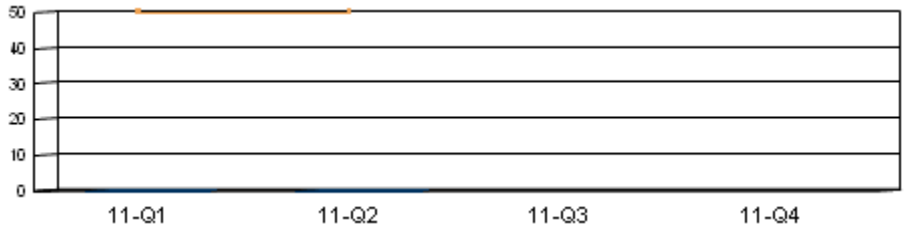
Kingston General Hospital

Milestone #21

E4 Technology

50% of our automated medication dispensing system is in place

Indicator: Automated Medication Dispensing System in Place Throughout Inpatient Units Within the Hospital



	Actual	Target
11-Q1	0	**50**
11-Q2	0	**50**
11-Q3		
11-Q4		

Interpretation - Patient And Business:

Indicator changed for Fiscal '12 to "Selection of vendor for implementation of Automated Dispensing Cabinets"
Preferred vendor has been selected. Contract negotiations with vendor coordinated by 3SO involving Finance, IM and Pharmacy. To be presented at Operations for approval

Definition: Automated dispensing cabinets improve patient safety, workflow efficiency, cost analysis and offer secure storage of medications. Indicator is % of locations stocked with medications with cabinets installed.

Target: Target 11/12: 50%

Strategy milestone # 22

Our lab order and DI management system is in place

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
Technology	**Rapid transmission of information improves care and operational efficiency**	**Introduce lab and diagnostic imaging order management systems**
Indicator(s)		**Status**
Implementation of an Order Management System for Labs on All Inpatient Areas		**Green**

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   This project has been a real success in the year. It has ended on schedule, and we are already seeing improvement on time to turnaround tests, reductions in errors, and cost savings.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   We were late in being able to start due to difficulty finding project leadership resources, however it ended on schedule due to significant effort by the full lab and clinical teams and the project manager. Education has been key in moving staff to adopt the new processes, and it has not been easy. We will adopt learning into the next phase of the project, which will expand to additional clinical areas and to our partner organizations.

3. **Are we on track to meet the milestone by year end?**
   Targets for year end were met.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   We continue to monitor and review the outcomes to ensure we can adapt the remaining phases as needed to continue to achieve our goals.

Kingston General Hospital

Milestone #22

				11-Q1	11-Q2	11-Q3	11-Q4	
E4 Technology	Our lab and diagnostic imaging order managment		Implementation of an Order Management System for Labs on All Inpatient Areas (% completion).	G	R	R	G	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

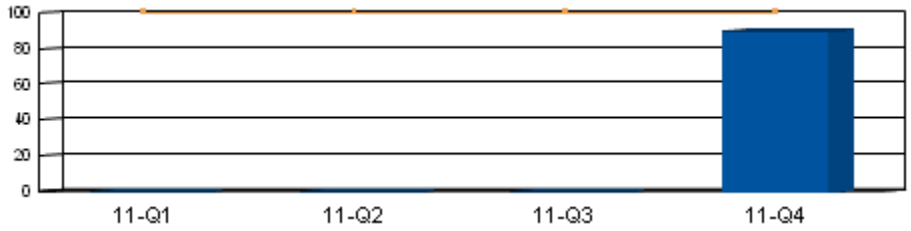
Kingston General Hospital

Milestone #22

E4 Technology

Our lab and diagnostic imaging order managment systems are in place

Indicator: Implementation of an Order Management System for Labs on All Inpatient Areas (% completion).



	Actual	Target
11-Q1	0	**100**
11-Q2	0	**100**
11-Q3	0	**100**
11-Q4	90	**100**

Interpretation - Patient And Business:

Project is moving along very well under the direction of project manager (M. MacInnis). The project manager was assigned to the project in October 2011. An aggressive roll out plan was prepared focusing on education, technology and implementation (workflow changes in the various areas). By end of Q4 a compliance rate for the inpatient areas was 89.7%.
Work still needs to be done for the 2nd phase of the project which will focus on the outpatient areas such as HDH, Renal, ER and FAPC.
A reduction in error rates for specimen collection is being reported, with an improved results turnaround times for routine testing. Final plans for phase II of the unit order entry project have not been finalized as of yet.

Definition: The goal of the electronic order entry project is to reduce patient risk involved with specimen collection and assist us in meeting Ontario Lab Accreditation standards. The project will introduce efficiencies in clerical time by reducing data entry in the diagnostic areas, while improving our capacity to deliver result more quickly to clinical staff. Existing technologies are being leveraged in order to achieve our goal.

The indicator we will be calculating to measure our success in transitioning to the new system is the percentage of tests that are ordered electronically on the unit over the total number of tests ordered.

Target: Target 11/12: 100%

Strategy milestone # 23

Timely e-discharge summaries are completed for every patient

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
Technology	Rapid transmission of information improves care and operational efficiency	Implement electronic discharge for every patient

Indicator(s)	Status
Percent of Discharge Communication Sent to Continuing Care Provider Within 72hrs of Patient Discharge	Red

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   We achieved 43% by year end of discharge summaries being signed off and distributed to continuing care provider (CCP), which fell short from our target of 80%. However we have increased the use of the electronic discharge tool and overall improved performance with getting more discharges completed within 120 hours . And 95% of patients are leaving with a copy of their discharge summary at time of discharge (many still draft/unsigned). Improvements have definitely been incurred and while discharges are being completed we are still having difficulty getting them signed within 72 hours and this is required before continuing care providers can receive.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   We are still exploring ways to simplify the signoff by the attending physicians who still find it difficult to review and complete within 72 hours.

3. **Are we on track to meet the milestone by year end?**
   We did not meet the milestone for 2012, but continue to work on this initiative and have retained the 80 percent target for 2013.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Information management and medical affairs continue to work on this initiative and are exploring both policy framework and electronic means to simplify the signoff by attending physicians. Education also is an ongoing tool to ensure new staff are up to speed and aware of the expectations for early signoff of discharge summaries. Again the more the electronic discharge summary is used the higher the compliance with the targeted time frame for sending the summary to the CCP.

Kingston General Hospital

Milestone #23

				10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
E4 Technology	Timely E-Discharge summaries are completed for every		Percent of Discharge Communication sent to Continuing Care Provider within 72 hours of Patient Discharge	N/A	R	R	R	R	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

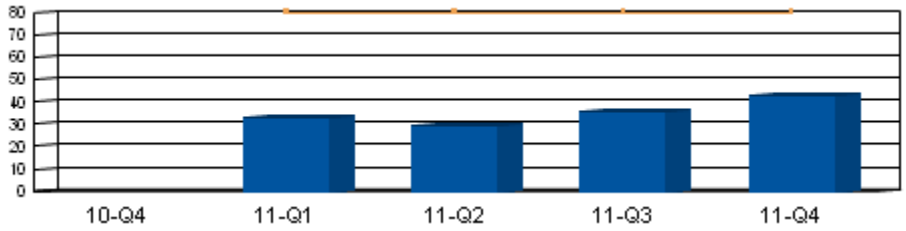
Kingston General Hospital

Milestone #23

E4 Technology

Timely E-Discharge summaries are completed for every patient

Indicator: Percent of Discharge Communication sent to Continuing Care Provider within 72 hours of Patient Discharge



	Actual	Target
10-Q4		
11-Q1	33	**80**
11-Q2	29	**80**
11-Q3	36	**80**
11-Q4	43	**80**

Interpretation - Patient And Business:

Fourth quarter results of 43% represent the best performance year to date and the single greatest performance gain (7%) in any quarter. The overall number of chart deficiencies has been reduced significantly. This improvement has been acknowledged by leaders in the primary care community.

Actions & Monitoring Underway to Improve Performance:

An analysis of our Q4 performance indicates that 95% of all discharge summaries were complete and available for patients at time of discharge, but only 43% were signed and therefore available for distribution to primary care. Our challenge continues to be signature compliance by our attending physicians. Health Information Services will continue to work collaboratively with Medical Administration and other key stakeholders to continue to find additional process and system solutions to ensure continued improvement to this indicator.

Definition: The percentage is based on the total number of discharges for the quarter versus the number of discharge summaries available for distribution to the Family Physicians within 72 hours from discharge. NB. Normal newborn and deliveries do not require discharge summaries so these numbers have been excluded from the calculation.

Target: QIP Target 11/12: 80%

Strategy milestone # 24

Our operating deficit is eliminated and our capital spend reaches $12 million

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
Finances	**Our operating budget is balanced and we are able to allocate $20 million a year to capital expenditures**	**Eliminate our operating deficit and build our capital investment capacity**

Indicator(s)	Status
Total Dollars for Capital Equipment	**Green**
Total Margin	**Green**

1. **What is our actual performance on each of the indicators for this milestone as listed above?**

   As at March 31, 2012 we did achieve our goal of $12 million being available to spend.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**

   Several factors contributed to this outcome: the work of teams across the organization to achieve operational savings, and the capital committee/finance/CFO all focus on managing resources to ensure all available funds were aligned or directed to capital wherever possible, and improved funding for HIRF from province.

3. **Are we on track to meet the milestone by year end?**

   Target was met for year end.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**

   The organization remains focused at all levels to achieve the ongoing capital spending allocation milestone for 2015. The operational review process will get underway again early in fiscal 2013 to continue to look at benchmark information to look for dollars to allocate from operations to capital budget again.

Kingston General Hospital

Milestone #24

			10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
E5 Finances	Our operating deficit is eliminated and our capital spend reaches $12 million	Current Ratio	G	G	G	G	G	↑
		Hospital Operations Actual vs Plan Variance ($000's)	G	G	G	G	G	↑
		Total Dollars for Capital Equipment ($000's)	Y	Y	Y	Y	G	↑
		Total Margin	G	G	G	G	G	↑
		Working Capital ($000's)	G	G	G	G	G	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

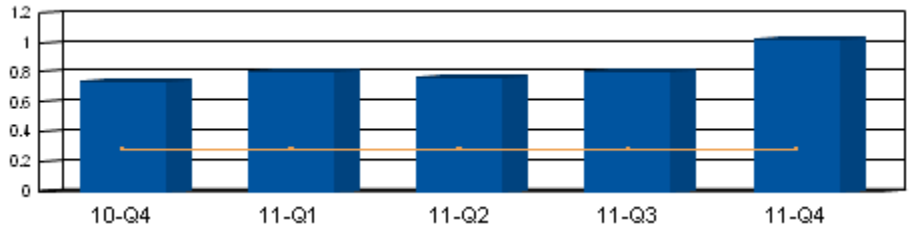
Kingston General Hospital

Milestone #24

E5 Finances

Our operating deficit is eliminated and our capital spend reaches $12 million

Indicator: Current Ratio



	Actual	Target
10-Q4	0.74	0.28
11-Q1	0.80	0.28
11-Q2	0.77	0.28
11-Q3	0.80	0.28
11-Q4	1.02	0.28

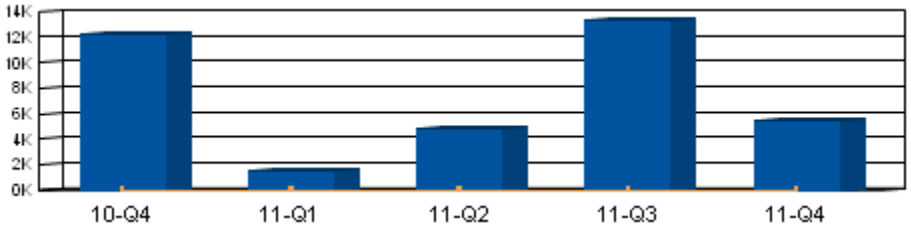
Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: This is a measure of liquidity indicating the facility's ability to meet short-term obligations. It is calculated by dividing Current Assets by Current Liabilities and comparing to 1. A measure of less than 1.0 means that the hospital is at risk of not being able to meet its current commitments and has limited opportunity to invest in the future (for further information see Working Capital Template).

Target: Baseline 08/09: 0.54, Target 09/10: 0.46, Target 10/11: 0.28, Target 11/12 0.28

Indicator: Hospital Operations Actual vs Plan Variance ($000's)



	Actual	Target
10-Q4	12265	0
11-Q1	1528	0
11-Q2	4875	0
11-Q3	13359	0
11-Q4	5532	0

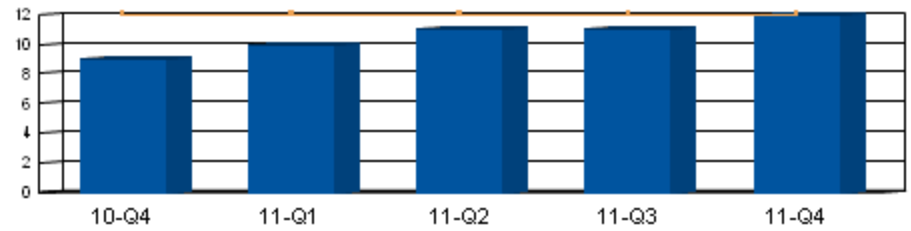
Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: The Hospital operations variance is a comparison of the operating fund surplus or deficit versus planned. It is calculated by subtracting net actual operating expenses [excludes net facility capital] compared to plan. It measures the degree to which the hospital is able to plan, monitor, and live within its financial resources.

Target: Baseline 08/09: 9892, Target 09/10: 0, Target 10/11: 0, Target 11/12: 0

Indicator: Total Dollars for Capital Equipment ($000's)



	Actual	Target
10-Q4	9	12
11-Q1	10	12
11-Q2	11	12
11-Q3	11	12
11-Q4	12	12

Actions & Monitoring Underway to Improve Performance:

The provision for capital investment capacity achieved$12.4M for the fiscal 2012 year; slightly exceeding the $12M target.

Definition: Total amount available for capital investment. Calculated as net equipment amortization less long-term loan payments.

Target: Target 11/12: 12M

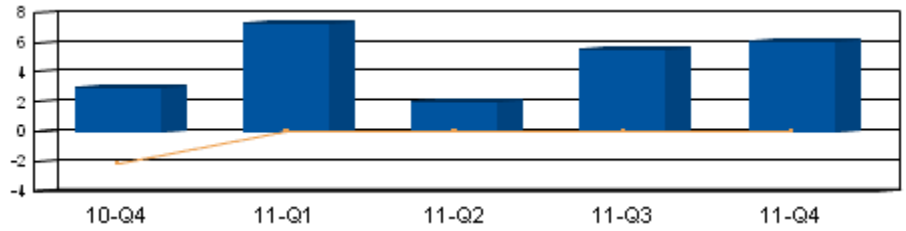
Kingston General Hospital

Milestone #24

E5 Finances

Our operating deficit is eliminated and our capital spend reaches $12 million

Indicator: Total Margin



	Actual	Target
10-Q4	2.95	**-2.17**
11-Q1	7.32	**0**
11-Q2	2.01	**0**
11-Q3	5.59	**0**
11-Q4	6.03	**0**

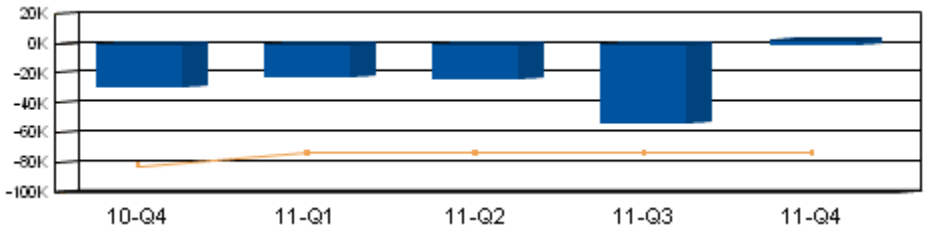
Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: Operating margin "measures total operating revenues in excess of total expenses". It is a measurement of management's efficiency and the hospital's ability to live within available financial resources. Calculated as: Operating Surplus/(Deficit) divided by Operating Revenue. To ensure consistency in calculation between hospitals, the Province has provided a specific definition based on the Hospitals MIS Chart of Accounts. It is inclusive of all fund types (fund 1, 2, and 3), but excludes facility amortization).

Target: Baseline 08/09: (3.9%), Target 09/10: (4.0), Target 10/11: (2.17), Target 11/12: 0

Indicator: Working Capital ($000's)



	Actual	Target
10-Q4	-28451	**-82352**
11-Q1	-22214	**-74000**
11-Q2	-23560	**-74000**
11-Q3	-53191	**-74000**
11-Q4	2035	**-74000**

Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: Working Capital (WC) is the net result of Current Assets (CA) less Current Liabilities (CL). A positive position (CA>CL) indicates funds exist in excess of current obligations, and a negative position (CL<CA) indicates an inability to meet current obligations with current resources. KGH is currently in a negative working capital position and reliant on support from the SE LHIN to ensure ample cash flow to meet current obligations.

Target: Baseline 08/09: (50413), Target 09/10: (76369), Target 10/11: (82000), Target 11/12: (74000)

Strategy milestone # 25

Patient, staff and stakeholder engagement takes place through improved website and social media tools

Strategic Direction	KGH 2015 outcome	Fiscal 2012 initiative
Communication	We continue to engage and report openly and regularly on our progress	Improve engagement using modern communication and collaboration tools

Indicator(s)	Status
Implementation of Improved Website and Social Media Tools	Green

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   - All information, policies and procedures pertaining to the FOI Legislation went live on the KGH website on Jan. 3 in accordance to the MOHLTC's directive.
   - KGH executive contracts and information pertaining to our compensation philosophy were proactively disclosed in January.
   - A user needs assessment study (consultation, online surveys, benchmarking) of internet/intranet use is now complete. A three-year joint web strategy to ensure web-based communication meets organizational and stakeholder needs is underway.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Working collaboratively with IM and PSOE ensured that KGH was compliant with all the requirements of the FOI Legislation, and the information posted on the KGH website demonstrated public transparency and accountability.

3. **Are we on track to meet the milestone by year end?**
   This milestone has been successfully met.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   - The work we've done collaboratively with IM to enhance stakeholder engagement through improved website and social media tools serves as a solid foundation we will continue to build on and improve.
   - Web strategy will be delivered by September.

Kingston General Hospital

Milestone #25

				11-Q1	11-Q2	11-Q3	11-Q4	
E6 Communication	Patient, staff, and stakeholder engagement takes		Implementation of Improved Website and Social Media Tools	G	G	G	G	↑

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

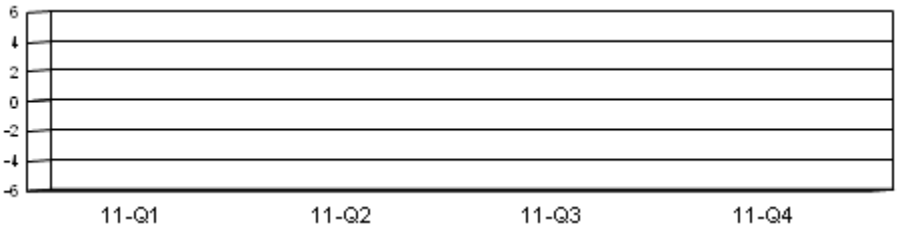
Kingston General Hospital

Milestone #25

E6 Communication

Patient, staff, and stakeholder engagement takes place through improved website and social media tools

Indicator: Implementation of Improved Website and Social Media Tools



	Actual	Target
11-Q1		
11-Q2		
11-Q3		
11-Q4		

Interpretation - Patient And Business:

On the final week of Q4 (Mar26, 2012 and April 1, 2012) KGH Connect.ca, which was launched in November, 2011, registered 97 visits, which represents a 73% increase of new visits since the week prior; 185 pages were viewed, and people who visited our site spent 1.5 minutes. Social media has allowed us to share information about KGH with key stakeholders in real-time, Since the site was launched we are seeing a steady increase in membership registration, and growing public interest in videos posted to our KGH YouTube channel. Active participation with Twitter and blogs posted by KGH President and CEO, Leslee Thompson, has increased the number of "followers" on our social media sites.

Actions & Monitoring Underway to Improve Performance:

Research to assess the internet and intranet needs of key user groups at KGH, was completed in Q4. The information will be used in conjunction with best practices to make improvements to the website including, content development, navigation and management. In partnership with IM, we will begin to develop a web strategy and implementation plan in the new fiscal year.

Definition: Purpose:
KGH will continue to engage and report openly and regularly on our progress: KGH is dedicated to building on the momentum of stakeholder engagement that helped shape KGH 2015. We are committed to communicating with internal and external stakeholders on our progress in ways that exemplify our guiding principles of respect, transparency, engagement, accountability and value for money.

Importance:
We will continue to engage our stakeholders through enhanced communication tools and techniques that will strengthen the KGH brand, instill public confidence in the organization, and help to achieve its aim, outstanding care, always.

Calculation:

- Staff and public engagement metrics
- Brand awareness metrics

Target: Target 11/12: Yes

Kingston General Hospital

Performance Report (KPI)
Q4 F2011 - 2012

				10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	Overall patient satisfaction is at or better than the provincial teaching hospital average		Overall Acute Care Patient Satisfaction (%)	G	G	G	G	N/A	↑
			Overall Emergency Care Patient Satisfaction (%)	G	G	G	G	N/A	↑
			Percent of Patients who Answer "Definitely Yes" to the NRC Picker Question " Would you recommend this Hospital to Your Friends and	R	Y	G	G	N/A	↑
	70% of our people who are surveyed rate us as		Hospital Standardized Mortality Ratio (HSMR)	G	G	G	R	N/A	↓
	The number of new cases who acquire infections in our hospital is reduced by 10%		C-difficile	R	R	R	R	R	↓
			Central Line Bloodstream Infections	G	G	R	G	G	↑
			MRSA (Methicillin-resistant Staphylococcus aureus)	Y	Y	Y	G	G	↑
			Number of New Cases of Hospital Acquired Infection	R	G	Y	Y	R	↓
			Surgical Site Infection (SSI) Prevention	Y	Y	Y	Y	Y	↑
			Ventilator Associated Pneumonia	G	G	G	G	G	↑
			VRE (Vancomycin-resistant Enterococcus)	G	Y	Y	G	G	↓
	We achieve 100% hand hygiene compliance across		Hand Hygiene Compliance	G	Y	Y	G	G	↑
	100% of our clinical services discharge patients at their expected LOS		Average # ALC Patients per Day	G	R	R	G	G	↑
			Overall - Acute Average Length of Stay Days (Based on HSAA)	Y	Y	G	Y	N/A	↓

				10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	100% of our clinical services discharge patients at their expected LOS		Overall - Acute Average Length of Stay vs. ELOS (Variance)	G	G	G	G	N/A	↑
			Percent ALC Days	R	Y	Y	G	N/A	↑
			Percent of Clinical Services Meeting ELOS Target	R	R	R	R	N/A	↓
			Readmission rate Within 30 Days for Selected CMG's	R	R	N/A	N/A	N/A	
	90% of patients receive their elective surgery within or faster than the provincially targeted wait time		All Cancer Surgery Wait time - 90th Percentile Wait Time (Days)	G	G	G	G	G	↓
			All Paediatric Surgery - 90th Percentile Wait Time (Days)	R	R	R	R	R	↑
			Cardiac Bypass Surgery - 90th Percentile Wait Time (Days)	G	G	G	G	G	↑
			Coronary Angiography - 90th Percentile Wait Time (Days)	G	G	G	G	G	↑
			Coronary Angioplasty - 90th Percentile Wait Time (hrs)	G	G	G	G	G	↑
			Diagnostic Imaging - CT – 90th Percentile Wait time (Days)	G	G	G	G	G	↓
			Diagnostic Imaging- MRI – 90th Percentile Wait time (Days)	R	R	R	R	R	↑
			General Surgical Procedures (Excluding Confirmed and Suspected Cancer Surgeries) - 90th Percentile Wait Time (Days)	G	G	G	R	R	↓
			Orthopedic Hip and Knee Replacement Surgery - 90th Percentile Wait Time (Days)	G	G	G	G	G	↑
			Orthopedic Surgery (excluding total hip and knee replacements) - 90th Percentile Wait Time (Days)	R	R	R	R	R	↑
			Percent of Total Surgical Wait Times Meeting or Exceeding 90th Percentile Wait Time Targets	R	R	R	R	R	↓
			Radiation Wait time (Referral-Consult) Percent seen within 14 days	G	G	R	R	N/A	↑

				10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	The ED wait time for admitted patients is less than 8 hrs for 100% of patients		90th Percentile ED Wait Time (All Admitted Patients)	R	G	G	G	G	↓
			Non-Admitted Patients with Minor or Uncomplicated Conditions in the Emergency Department (ED) - 90th percentile wait time (hrs)	R	R	R	R	R	↑
			Patients Admitted from the Emergency Department (ED) with Complex Conditions - 90th percentile wait time (hrs)	R	R	R	R	R	↓
			Percent of Non-Admitted High Acuity Patients Treated Within a Wait Time Target of <8hrs (CTAS 1-2) & <6hrs (CTAS 3)	R	G	G	G	G	↑
			Percent of Non-Admitted Low Acuity Patients (CTAS 4&5) Treated Within a Wait Time Target of <4hrs	R	R	R	R	R	↑
			Percent of Patients Admitted (from the Emergency Department) within a wait time target of <8 hrs	Y	G	Y	G	Y	↓
SD3 Cultivate patient oriented research	Externally funded research at KGH has increased by 10% and our clinician scientist program expands		Active Clinical Trials	G	G	G	G	G	↑
			Clinical Trials Generating Revenue	G	G	G	G	G	↑
			New Clinical Trials	G	G	R	R	G	↑
			Percent Increase of Externally Funded Research Dollars at KGH	N/A	N/A	G	G	G	↑
SD4 Increase our focus on complex-acute and specialty care	100% of Target service volumes are met		Stem Cell Transplants	G	G	G	G	G	↑
			Ambulatory Care Volumes	G	G	G	G	G	↑
			Cardiac - Angiography Volumes	G	G	G	G	G	↑
			Cardiac - Angioplasty Volumes	G	G	G	G	G	↑
			Cardiac - Bypass Volumes	G	G	G	G	G	↑
			Chronic Kidney Disease Program- Weighted Units	G	G	G	Y	G	↑

				10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
SD4 Increase our focus on complex-acute and specialty care	100% of Target service volumes are met		CT Hours (Wait Time Strategy Allocation)	G	G	G	G	G	↑
			Emergency Department Admitted Patient Volumes – All Levels of Acuity	G	G	G	G	G	↑
			Emergency Department Non-Admitted Low Acuity (CTAS 4&5) volumes	G	G	G	G	G	↑
			Emergency Department Non-Admitted Patient Visits – High Acuity	G	G	G	G	G	↑
			Hip and Knee Replacement Volume (Wait Time Strategy Allocation)	G	Y	Y	G	Y	↓
			Kidney Transplants	Y	G	R	R	G	↑
			MRI Hours (Wait Time Strategy Allocation)	R	G	Y	G	G	↑
			OR Cases (Inpatient and Outpatient))	G	G	G	G	G	↑
			OR Hours (Inpatient & Outpatient)	Y	G	G	G	G	↑
			Percent of Wait Time Contracted Volumes Achieved	N/A	R	Y	Y	Y	↓
			Total Inpatient Admissions	G	G	G	G	G	↑
			Total Inpatient Weighted Cases	G	G	G	G	N/A	↑
E1 People	Lost time injury claims are reduced by 10%		Lost Time Injury Claims	N/A	Y	Y	Y	R	↓
			Musculoskeletal Injuries (MSIs)	R	G	R	R	R	↑
			Percent Completion of Incident Investigations	R	R	R	Y	R	↓
			Reduction in Lost Time Injury Claims due to Musculoskeletal Injuries	N/A	R	R	Y	R	↓

				10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
E1 People	Lost time injury claims are reduced by 10%		Reduction in Needle Stick Injuries	N/A	R	Y	R	G	↑
	Average sick days per KGH employee are reduced to 10.5		Average Sick Days per Eligible Employee Per Year	Y	Y	Y	Y	Y	↓
			Percent of Overtime Hours	Y	Y	Y	Y	Y	↓
			Percent Sick Time Hours	G	Y	Y	Y	Y	↓
			Total Full Time Equivalents (FTE's)	Y	G	G	G	G	↑
E4 Technology	Timely E-Discharge summaries are completed for every		Percent of Discharge Communication sent to Continuing Care Provider within 72 hours of Patient Discharge	N/A	R	R	R	R	↑
E5 Finances	Our operating deficit is eliminated and our capital spend reaches $12 million		Current Ratio	G	G	G	G	G	↑
			Hospital Operations Actual vs Plan Variance ($000s)	G	G	G	G	G	↑
			Total Dollars for Capital Equipment ($000s)	Y	Y	Y	Y	G	↑
			Total Margin	G	G	G	G	G	↑
			Working Capital ($000's)	G	G	G	G	G	↑

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

Kingston General Hospital

Quality Improvement Plan (QIP)
Q4 F2011 - 2012

				10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	15 Patient experience advisors are integrated into		Number of Patient Experience Advisors on Key Planning/Decision Making Forums	Y	G	G	G	G	↑
	Overall patient satisfaction is at or better than the provincial teaching hospital average		Percent of Patients Responding "Satisfied" to the Food Patient Discharge Survey	R	R	R	R	N/A	↓
			Percent of Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey (QIP)	Y	G	G	G	N/A	↓
			Percent of Patients who Answer "Definitely Yes" to the NRC Picker question "Would you Recommend this Hospital to your Friends and	Y	G	G	G	N/A	↑
	70% of our people who are surveyed rate us as "Excellent" in fostering patient safety culture		Hospital Standardized Mortality Ratio (HSMR)	G	G	G	R	N/A	↓
			Percent Mortality Reviews Completed with Quarterly Review of Record Level HSMR Data	G	N/A	N/A	N/A	N/A	
	The number of new cases who acquire infections in our hospital is reduced by 10%		Anti-biotics Dispensed Quarterly to ED and Admitted Patients per 1000 patient days	R	R	Y	R	Y	↑
			C-difficile (QIP)	R	G	R	R	R	↓
			Environmental Audits	G	Y	G	G	G	↓
			Percent of Sepsis Cases Reviewed by Department Head	N/A	N/A	N/A	N/A	N/A	
			Ventilator Associated Pneumonia (QIP)	G	G	G	G	G	↓
	We achieve 100% hand hygiene compliance across all units and staff		Hand Hygiene Compliance (QIP)	N/A	Y	Y	G	G	↑
	100% of our clinical services discharge patients at their expected LOS		Average # ALC Patients per Day	G	R	R	G	G	↑
			Percent ALC Days	R	Y	Y	G	N/A	↑

				10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	100% of our clinical services discharge patients at their expected LOS		Percent of Clinical Services Meeting ELOS Target	R	R	R	R	N/A	↓
			Readmission rate Within 30 Days for Selected CMG's	R	R	N/A	N/A	N/A	
	The ED wait time for admitted patients is less than 8 hrs for 100% of patients		90th Percentile ED Wait Time (All Admitted Patients)	R	G	G	G	G	↓
SD2 Bring to life new models of interprofessional	100% of our clinical areas have implemented ICPM		Implementation of ICPM in All Inpatient Units and Extended to Ambulatory Setting by March 2012	N/A	G	G	G	G	↑
E1 People	Average sick days per KGH employee are reduced to 10.5 days		Average Sick Days per Eligible Employee Per Year	Y	Y	Y	Y	Y	↓
E4 Technology	Timely E-Discharge summaries are completed for every patient		Percent of Discharge Communication sent to Continuing Care Provider within 72 hours of Patient Discharge	N/A	R	R	R	R	↑
E5 Finances	Our operating deficit is eliminated and our capital spend		Total Margin	G	G	G	G	G	↑

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

Kingston General Hospital

Strategy Scorecard (SSC)
Q4 F2011 - 2012

				10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	15 Patient experience advisors are integrated into		Number of Patient Experience Advisors on Key Planning/Decision Making Forums	Y	G	G	G	G	
	Overall patient satisfaction is at or better than the provincial teaching hospital average		Overall Acute Care Patient Satisfaction (%)	G	G	G	G	N/A	
			Overall Emergency Care Patient Satisfaction (%)	G	G	G	G	N/A	
			Percent of Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey	G	G	G	G	N/A	
	70% of our people who are surveyed rate us as excellent		Percent of Staff surveyed who Rate KGH "Very Good" or "Excellent" on the Patient Safety Culture Survey	R	R	N/A	N/A	R	
	The number of new cases who acquire infections in our hospital reduced		Number of New Cases of Hospital Acquired Infection	R	G	Y	Y	R	
	We achieve 100% hand hygiene compliance across all units and staff		Hand Hygiene Compliance (SSC)	N/A	Y	Y	Y	G	
	100% of our clinical services discharge patients at their expected LOS		Overall - Acute Average Length of Stay vs. ELOS (Variance)	G	G	G	G	N/A	
			Percent ALC Days	R	Y	Y	G	N/A	
			Percent of Clinical Services Meeting ELOS Target	R	R	R	R	N/A	
	90% of patients receive their elective surgery within expected LOS		Percent of Total Surgical Wait Times Meeting or Exceeding 90th Percentile Wait Time Targets	R	R	R	R	R	
	The ED wait time for admitted patients is less than 8 hrs for 100% of patients		Percent of Patients Admitted (from the Emergency Department) within a Wait Time Target of <8Hrs (SSC)	R	R	R	R	R	
SD2 Bring to life new models of interprofessional care and education	100% of our clinical areas have implemented ICPM		Implementation of ICPM in All Inpatient Units and Extended to Ambulatory Setting by March 2012	N/A	G	G	G	G	
	The KGH Interprofessional education council		IPE Work Plan Launched	G	G	G	G	G	

				10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
SD3 Cultivate patient oriented research	Externally funded research at KGH has increased by 10% and our clinician scientist program expands		Expand Number of Clinician Scientists	N/A	G	G	G	G	↑
			Percent Increase of Externally Funded Research Dollars at KGH	N/A	N/A	G	G	G	↑
			Research Institute Business and Operating Plan Delivered	N/A	N/A	N/A	N/A	G	
SD4 Increase our focus on complex-acute and specialty care	KGH clinical staff adopt evidence-based		Number of Clinical Areas that have Implemented Open Source (OS)	N/A	G	R	G	G	↑
	KGH services align with our role as the region's complex-acute and specialty care provider and the Cancer Care at KGH strategic plan		KGH Cancer Care Plan	N/A	G	G	G	G	↑
			KGH Participation in Clinical Services Roadmap Initiatives	N/A	G	G	G	G	↑
	100% of Target service volumes are met		Percent of Wait Time Contracted Volumes Achieved	N/A	R	Y	Y	Y	↑
E1 People	Lost time injury claims are reduced by 10%		Lost Time Injury Claims	N/A	Y	Y	Y	R	↓
	Average sick days per KGH employee are reduced to 10.5		Average Sick Days per Eligible Employee Per Year	Y	Y	Y	Y	Y	↓
			Launch the Staff Scheduling Project	N/A	G	R	N/A	G	↑
	100% of our staff complete mandatory online training		Percent of Staff that Complete Mandatory Online Training Programs	N/A	R	Y	Y	Y	↑
E2 Processes	100% of KGH managers complete mandatory process		Percent of Management Staff Completing Mandatory Process Improvement Training	N/A	Y	R	N/A	N/A	
E3 Facilities	Our new solar farm is established and 50% of carpets are removed from inpatient areas		Percent of Square Footage of Carpet Removal Complete	N/A	G	G	G	G	↑
			Solar Farm Established	N/A	Y	R	R	N/A	↓
	96% of our Phase 1 redevelopment is complete on time, on budget, and new retail and nutrition facilities are in place		Phase 1 Redevelopment is Completed on Time and On Budget	N/A	G	G	G	N/A	↑
			Phase 2 Redevelopment Planning Started	N/A	G	Y	G	N/A	↑

				10-Q4	11-Q1	11-Q2	11-Q3	11-Q4	
E3 Facilities	96% of our Phase 1 redevelopment is complete on time,		Redevelopment (Space for new Clinical, Retail, Nutrition Facilities)	N/A	G	G	G	N/A	↑
E4 Technology	50% of our automated medication		Automated Medication Dispensing System in Place Throughout Inpatient Units Within the Hospital	N/A	G	R	N/A	G	↑
	Our lab and diagnostic imaging order management		Implementation of an Order Management System for Labs on All Inpatient Areas (% completion).	N/A	G	R	R	G	↑
	Timely E-Discharge summaries are completed for every		Percent of Discharge Communication sent to Continuing Care Provider within 72 hours of Patient Discharge	N/A	R	R	R	R	↑
E5 Finances	Our operating deficit is eliminated and our capital spend reaches $12 million		Total Dollars for Capital Equipment ($000s)	Y	Y	Y	Y	G	↑
			Total Margin	G	G	G	G	G	↑
E6 Communication	Patient, staff, and stakeholder engagement takes place		Implementation of Improved Website and Social Media Tools	N/A	G	G	G	G	↑

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